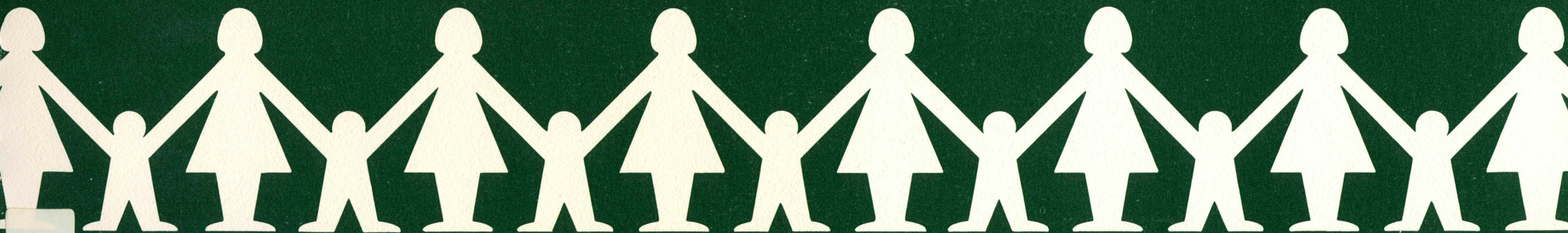


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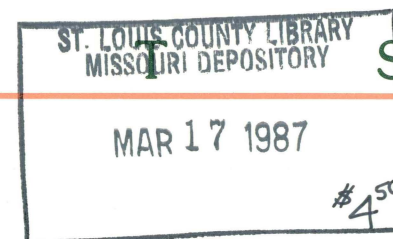
Two Generations At Risk



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GOVERNOR'S INTERAGENCY WORKING GROUP ON ADOLESCENT PREGNANCY

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P R E F A C E

Dear Governor Ashcroft:

Here within the Governor's Interagency Working Group on Adolescent Pregnancy respectfully submits to you our findings and recommendations resulting from our interagency study of adolescent pregnancy.

This study was performed at your request to assess the statewide dilemma of teenage pregnancy. Our study included an analysis of incidence and prevalence data, the consequences of adolescent childbearing, and identification of state-supported programs for pregnant adolescents and adolescent parents. In our final analysis, statewide goals were developed including recommendations for reducing the incidence and consequences of adolescent pregnancy.

We are grateful for your leadership on this long standing problem in need of new solutions.

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Co-chair, Governor's Interagency Working Group
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EXECUTIVE SUMMARY

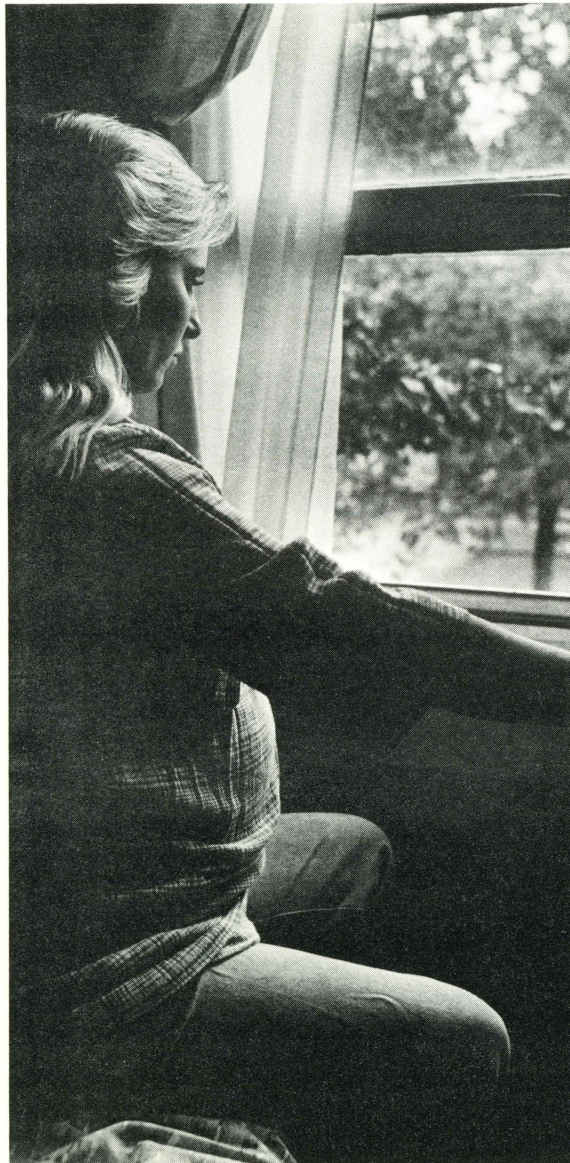
Adolescent pregnancy in Missouri represents serious medical, social and financial problems. When an adolescent becomes pregnant, her life and the life of her child often become susceptible to poverty, welfare dependence, and isolation. In addition, many adolescent mothers have poor health habits, lack adequate medical care, and face a greater likelihood of dropping out of school.

Clearly, teen pregnancy is one of the most complex and serious problems facing us today.

The consequences of adolescent pregnancy are often identified by health problems, loss of human potential, and low socioeconomic status.

Health Problems:

Further complicating the health status of both mother and child, teenagers often have poor personal health habits. Lack of adequate nutritional reserves and inadequate nutritional intake may contribute to a lack of nutrients necessary to produce a healthy baby. Infants born to teen mothers often face high medical risks. They are more likely to be born with low birth weight, to die during the first two years of life, and have a lower IQ than infants born to females in their twenties.



...more than half of all teen mothers will have a second pregnancy within two years.

Repeat pregnancy is common. In fact, more than half of all adolescent mothers will have a second pregnancy within two years. The mother who bears a second child while she is in her teens is at an even greater risk of medical complications during her second pregnancy than the first.

Education is often interrupted, and in most cases never completed, as a consequence of adolescent pregnancies. For mothers under age 30 with no high school

...mothers under age 30 with no high school diploma, 90 percent live in poverty.

diploma, 90 percent live in poverty. Study time, transportation and responsibility for day care act as barriers to completing one's education.

Teen fathers are also at risk of not completing their education. Often, the result of teen fathers' new responsibilities is an increased incidence of dropouts in order that they may obtain jobs to provide minimal financial support to the mother and child. Like the teen mother, the teen father's peer relationships are seriously hampered. Activities that could have led to possible scholarships, such as athletics, may be put aside to provide time for employment. His plans and life goals are also left unfulfilled and unresolved.

Low Socioeconomic Status:

Inadequate education, single parenthood (by choice or by consequences of high adolescent divorce rates), and lack of work experience help to perpetuate the poverty cycle of teen parents. Babies born to teenagers are three times as likely to be raised by a single parent, which is strongly associated with low economic status. Unemployment or underemployment only contributes to the poverty crisis and, in turn, contributes to health risks and inadequate medical care.

The societal costs of adolescent pregnancy are significant. In Missouri, over \$225 million per year is provided in the form of income assistance, food stamps,



and medical assistance to mothers who first gave birth as a teen. Approximately 53 percent of all Aid to Families with Dependent Children (AFDC) cases were mothers who first gave birth as teenagers. These costs continue to mount over time, particularly given the high likelihood of repeat pregnancies.

Recent research has also concluded that teen mothers are the group most likely to be dependent on welfare for long periods of time. This primarily is due to the low socioeconomic status, and the difficulty of overcoming the barriers of lack of education and work experience.

This report focuses on the limited role that public services perform or can perform to address this problem. The private

behavior and choice made by teens with regard to sexual activity and pregnancy depend little on the availability of public

Cultural values and the societal institutions... must be the focus of solutions...

services. Cultural values and the societal institutions that shape behavior — families, churches, neighborhoods, communities and schools — must be the focus of solutions to the problems presented by adolescent pregnancy. Without their involvement, the fast track to poverty continues.

Summary of Interagency Working Group Recommendations

Goal I: Reduce the Incidence of Adolescent Pregnancy

- Encourage adolescents to postpone sexual activity.
- Enable all children to obtain comprehensive health education, including life skills instruction, through local school districts to promote the well-being of each child.
- Encourage the leadership of government, business, education, and the media to promote and develop teen pregnancy prevention programs.
- Explore the establishment of comprehensive health services in the schools in order to promote healthy lifestyles, including education, medical, and counseling accessible to and appropriate for teens.
- Target teen pregnancy prevention programs to adolescent males as well as females.
- Encourage adolescents to postpone parenthood by increasing teenagers' positive views of their future opportunities and themselves.
- The State, employers, and local communities should take steps to address the chronic and worsening high rate of adolescent unemployment, particularly among minorities.

Goal II: Reduce the Consequences of Adolescent Pregnancy

- Establish programs to assist adolescent parents to finish high school.
- Target employment and training programs to adolescent parents to increase life options and increase the sense of financial responsibility.
- Increase the opportunities for adolescents to participate in group and individual parenting education classes.
- Encourage families and community institutions — PTAs, churches, etc. — to provide the awareness in young people of the responsibility of parenthood.
- Increase access to prenatal and primary health care for children and their families.
- Increase the availability of quality, affordable day care so that teen parents can participate in educational and job training programs.
- Government policies and programs, at federal and state levels, should encourage minor parents to remain with the adult caretakers.

Incidence of Adolescent Pregnancy and Births

I had been feeling bad for several weeks so my mom sent me to the doctor. I was 16 and had my license, so I went by myself. The doctor must have known by looking at me that I was probably pregnant. He was rough and uncaring. After my exam, he came into the room and told me that I had to call my mother and tell her right then or ask her to come over. He then told me it was because I was four months pregnant. I told him I couldn't be because my boyfriend and I hadn't gone all the way. We had just done it a little bit one time. He laughed at me. I wanted to be dead. I left the office and drove home beating my stomach and crying all the way. Just like me, my parents didn't believe it. It was a mess, and I still am a mess. I dropped out of school and dropped my friends. I wanted to die so bad. I'll never be the same. This all happened a year and a half ago, but it feels like yesterday. I'm back in school and am pretty much a loner. My old boyfriend has always wanted to keep our relationship going, but to see him breaks my heart. In fact, I think everybody who was involved had their heart broke. Either I wish I wouldn't have become pregnant or at least taken better care of myself while I was pregnant, maybe my little boy would have lived if I had.

Sarah, age 17, Kansas City

The Problem

Teenage pregnancy is a problem but it is neither new nor increasing in the United States. Rather, teenage pregnancy is a chronic problem being recognized for the burden it places on individuals and society. The number of teen pregnancies is actually declining and the rate appears to be stabilizing. The impression that teen pregnancy is on the increase is based on the comparison of the United States with other industrialized countries and on the increase in births to unmarried mothers. The U.S. pregnancy rate among teenage girls is more than twice that of the British, French and Canadian rates according to the Alan Guttmacher Institute.¹ The percent of births occurring to unmarried mothers has increased among all age groups, but most visibly among women 10-19. Over half of all births to women less than 20 are to unmarried mothers.

The number of teenagers has declined in the 1980s as the baby boom cohort

Over half of all births to women less than 20 are to unmarried mothers.

passed out of the teen years. There will not be an increase in the teen population until the end of the century. Consequently, it is not surprising to see a decrease in the actual number of teen pregnancies. Fertility rates are population-based, however, and these have also decreased. Recent national data shows U.S. birth rates for teenage mothers, age 15-19, declined 7 percent from 1975 to 1983.² The rates for mothers less than 15 have remained relatively unchanged for the past two decades.

According to the National Center for Health Statistics the highest birth rates among teenage mothers were reached in the early 1950s and have been decreasing each year since that time for all races. Births to women less than 20 years of age are an increasingly smaller proportion of total births, decreasing from 19 percent of all births in 1975 to 14 percent in 1983.

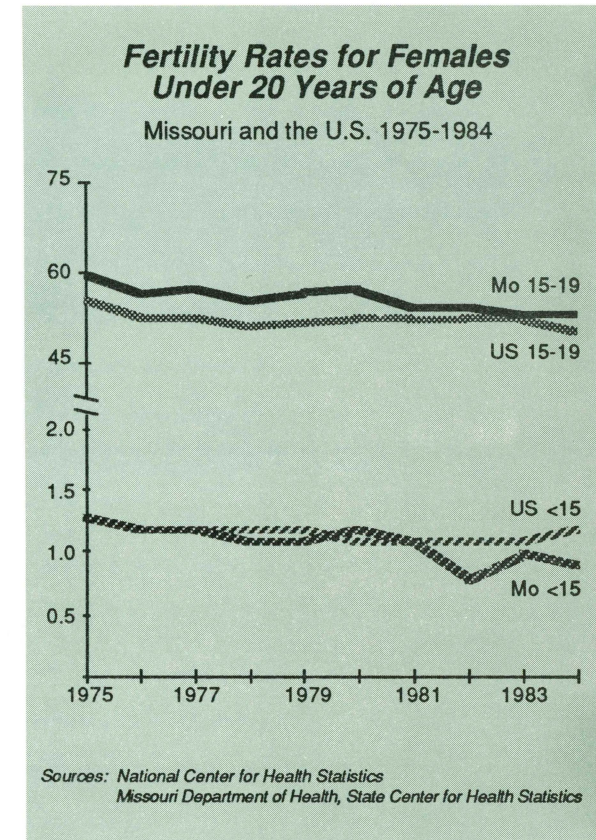
Of course, births are only one indicator of pregnancy — abortion is another. Although the Supreme Court's 1973 decision in *Roe v. Wade* led to the widespread availability of legal abortions, data on abortions are neither as recent nor as available as information on births and considerably less complete.³ Despite this shortcoming, the same pattern as in births appears to be present. The proportion of

total abortions obtained by teenage girls has declined each year since 1975. In addition, the ratio of abortions to births among teenagers remained relatively unchanged from 1979 through 1981. With the exception of the youngest teens, there were more births than abortions.

In 1983, 9.4 percent of babies born to mothers 15-19 years old in the United States weighed less than 2500 grams, compared to 6.8 percent of all births and 5.9 percent of the births to women 25-34. Low birth weight infants are at a higher risk of morbidity and mortality than are infants of normal birth weight. Consequently, the infants of women less than 20 and particularly those less than 17 run a higher risk of mortality than do the infants of older mothers.⁴

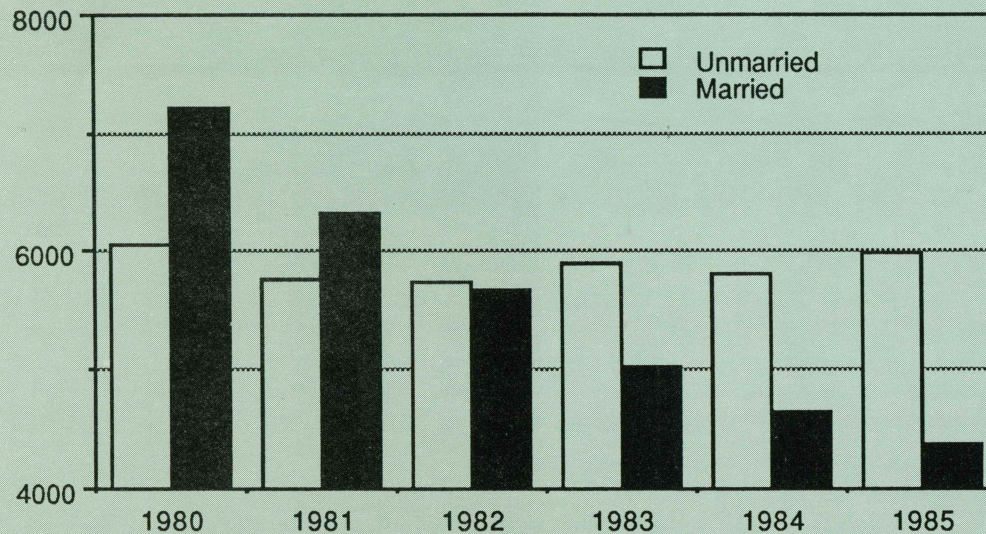
...infants of women less than 20 and particularly those less than 17 run a higher risk of mortality...

The lifestyle of teenagers is not conducive to providing the most opportune situation for child-bearing. In addition to any nutritional deficiencies or other adverse conditions, such as smoking, teen mothers are



less likely than older women to obtain prenatal care during the first trimester of pregnancy. In 1983, 76 percent of all births in the United States were to mothers who initiated prenatal care in the first trimester. Among women less than 20 years old, 54 percent of the births were to mothers who began prenatal care in the first trimester.

Births to Women 10-19 by Marital Status



Source: Missouri Department of Health, State Center for Health Statistics

Births to unmarried mothers are associated with lower levels of prenatal care. The percent of out-of-wedlock births is increasing for all but the oldest age groups. Although teenage mothers continue to have higher rates of births to unmarried mothers than do older mothers, their proportion of out-of-wedlock births has declined from over 50 percent to less than 37 percent.⁵

The higher rates of low birth weight, inadequate prenatal care and out-of-wedlock births mean that babies born to teen mothers are at higher risk than are those born to older women.

Teen pregnancy, particularly births to very young mothers, continues to present a complex challenge for which measures aimed at both preventing and alleviating the hardships are needed.

Teenage Pregnancy in Missouri

Missouri replicates the national trends with only minor deviations. The actual number of teen pregnancies is decreasing as the number of teenagers declines. The population of 15-19 year-olds will continue to decrease until the year 1995, although the 10-14 year old group will begin to increase in 1990. The proportion of all births to mothers under the age of 20 has decreased annually accounting for 13.5 percent of the 1985 births to Missouri residents.⁶

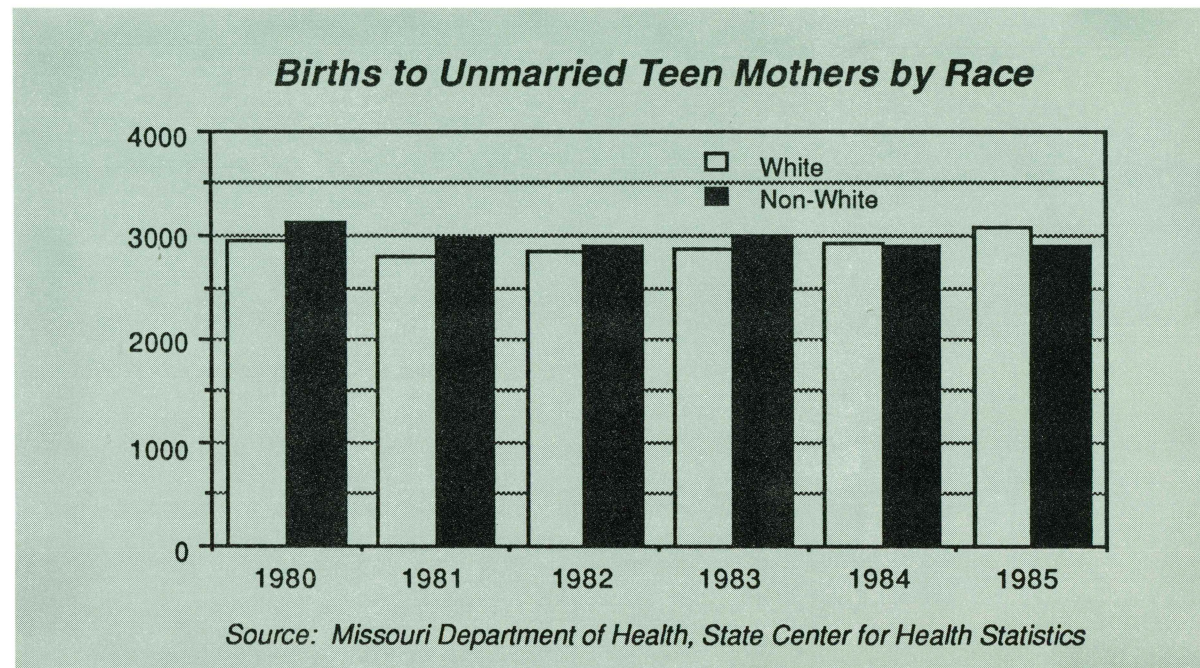
Fertility rates have apparently stabilized during the 1980s but continue to be higher than the national rates. Again, however, the current rates represent a decrease from the rates of the 1960s and 1970s and are approaching national rates. The percent of births to unmarried mothers continues to increase on an annual basis for all age groups. However, the proportion of all births that are to unmarried women which occur to women under the age of 20 is decreasing. In 1985, 57.8 percent of all births to mothers less than 20 years were to unmarried mothers.

Births to unmarried women and to teen mothers occur at a higher rate among nonwhites than among whites. The rate of

In 1984 and 1985, the actual number of births to unmarried white teen mothers exceeded the number for nonwhite births.

out-of-wedlock births among nonwhites appears to have stabilized. But among white births the percent of births to unmarried teen mothers increases yearly. In 1984 and 1985, the actual number of births to white teen mothers exceeded the number for nonwhite births. Teenage pregnancy and births to unmarried mothers are not confined to any racial group.

As with births, the number of abortions obtained by Missouri teens has declined steadily throughout the 1980s as has the proportion of abortions obtained by women less than 20. Missouri began collecting data on abortions in 1975 but reporting was not mandatory until mid-1976 after the *Planned Parenthood of Central Missouri v. Danforth* decision. However, Missouri has stringent reporting requirements and information on abortions performed in other states on Missouri residents is reported from cooperating states.



The proportion of all abortions obtained by teenage residents of Missouri has dropped from nearly one-third in 1980 to slightly over one-fourth in 1985. The ratio of abortions to pregnancies also declined over the same time period although one-third of teen pregnancies continue to be terminated. Only among teenagers less than 15 years old have the number of abortions exceeded the number of births.

The nonwhite ratio of abortions to births exceeds the white ratio nationally. Missouri

repeats this pattern for all age groups combined with the ratio of abortions to births higher among nonwhites than it is among whites. For teenagers the converse is true with the white ratio of abortions to births higher than the nonwhite ratio.⁷

These factors, however, vary with the age of the mother and the race of the child. Basically, the younger the mother, the less likely she is to initiate prenatal care in the first trimester and the more likely the baby will be born weighing less than 2500 grams

and out-of-wedlock. Nevertheless, it should be remembered that most teen births occur to older teens — approximately 64 percent of all births to teenage mothers are to women 18 and 19 years of age. These older teens have the highest rate of early care among women less than 20 and the lowest rates of low birth weight and out-of-wedlock births. There is also a higher incidence of traumatic deaths to infants of teenage mothers.

...a higher incidence of traumatic deaths occurs to infants of teenage mothers.

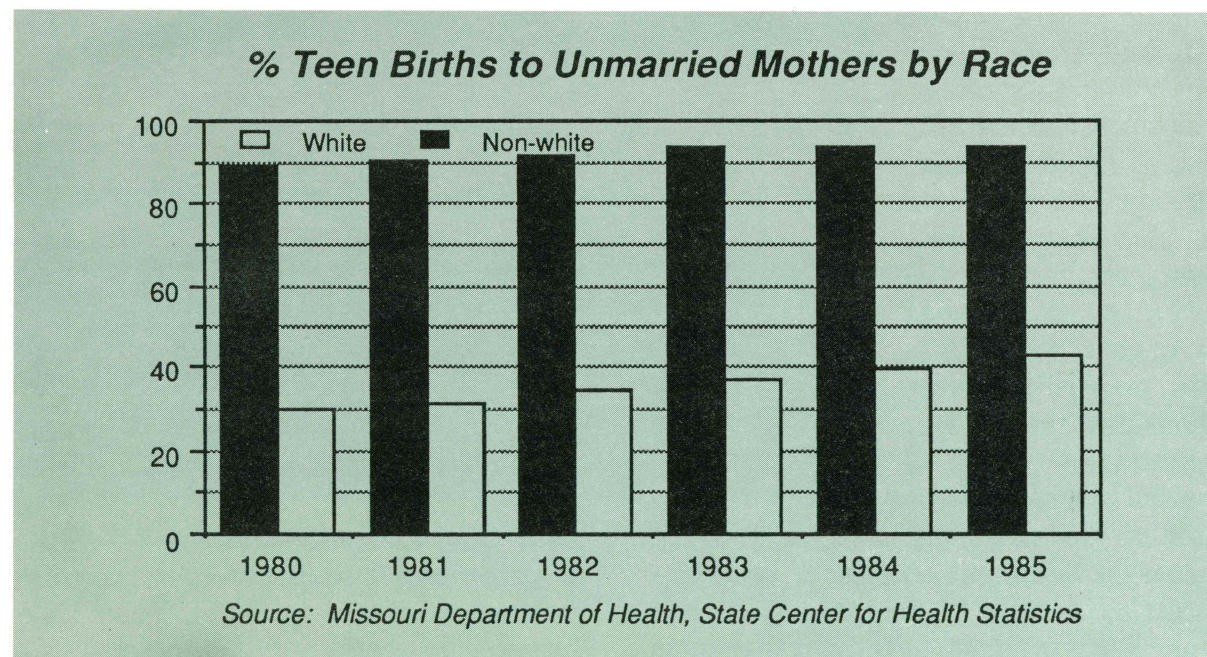
Births to nonwhite teenage mothers have slightly lower rates of early prenatal care than do white births. The difference between white and nonwhite births to teens is not as great as the difference between white and nonwhite births in general. In 1985, 58.2 percent of the white teenage mothers initiated care in the first trimester compared to 54.8 percent of the nonwhite teenage mothers. For all births, 81.7 percent of the white mothers sought early prenatal care in comparison to 67.2 percent of the nonwhite mothers. Nonwhite births

Nonwhite births to teenage mothers are twice as likely to be low birth weight and to be born out-of-wedlock...

to teenage mothers are twice as likely to be low birth weight and to be born out-of-wedlock than are white teenage births. These patterns reflect the racial differences in the general population where nonwhite

births are more than twice as likely to weigh less than 2500 grams and four times as likely to be born to unmarried mothers.

Teenage mothers have higher rates of infant mortality than do older mothers. During the past decade infant mortality has declined rapidly although it appears to be stabilizing. Consequently, the number of infant deaths occurring to any single category is small and it is necessary to combine several years of data to compare teenage mothers by age or race.



For infants born in the years 1980-1984 the death rate for births to teenage mothers was 16.7 when the overall infant mortality rate was 11.3 per 1,000 live births for the same period. Births to mothers less than 15 years of age have infant death rates more than twice those of even the 15-17 year old age group.

The infant mortality rate for white births was 9.8 for the 1980-1984 period, but for births to white teenagers the rate was 15.9. The higher rate for teenagers does not hold for nonwhites, however, where the overall infant mortality rate was 18.7 compared to 20.3 for nonwhite teenagers. The fact that infant mortality for white teenagers approaches the nonwhite rates illustrates the greater importance of age of mother at birth than the race of the mother as a factor in infant mortality. For women of all ages, nonwhite infant mortality is 90 percent higher than white infant mortality but among teenagers

the difference between nonwhite and white infant mortality is only 30 percent.

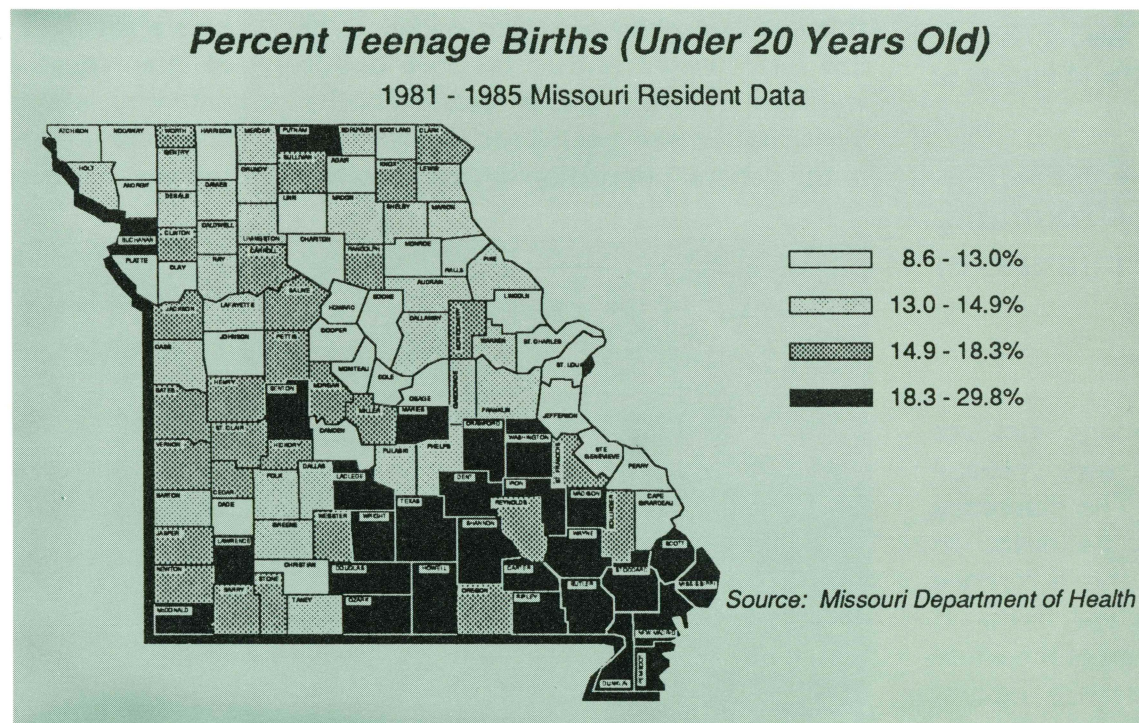
Regional Differences

The counties with the highest rates of teenage births are in the southeastern corner of the state (Bootheel) and in St.

The nonwhite population in Missouri is concentrated in the two major metropolitan areas of the state, St. Louis and Kansas City, and in the Bootheel. Only in St. Louis City does the number of nonwhite births exceed the number of white births.

Nonwhite births to mothers under the age of 18 also exceed white births to mothers under the age of 18 in Jackson and Pemiscot counties.

The juxtaposition of St. Louis City and St. Louis County represents the racial contrast in the state since the city is predominantly black and the county predominantly white. In 1985 the number of teen pregnancies were not too different (2,606 in St. Louis City, 2,317 in St. Louis County). Of these pregnancies in the City, 1,728 resulted in



Louis City. The greatest number of births to women less than 20, however, occurs in the metropolitan areas — St. Louis City, Jackson, St. Louis and Greene counties.

births and 853 in abortions per 1,000 births; in St. Louis County the number of abortions (1,206) exceeded the number of births (1,102) for a ratio of 1094:4 abortions

per 1,000 births.

Abortion services in the state are highly concentrated with the majority located in the St. Louis and Kansas City areas. It is not too surprising that among the general population and specifically among teenagers the abortion ratio is higher in these areas.

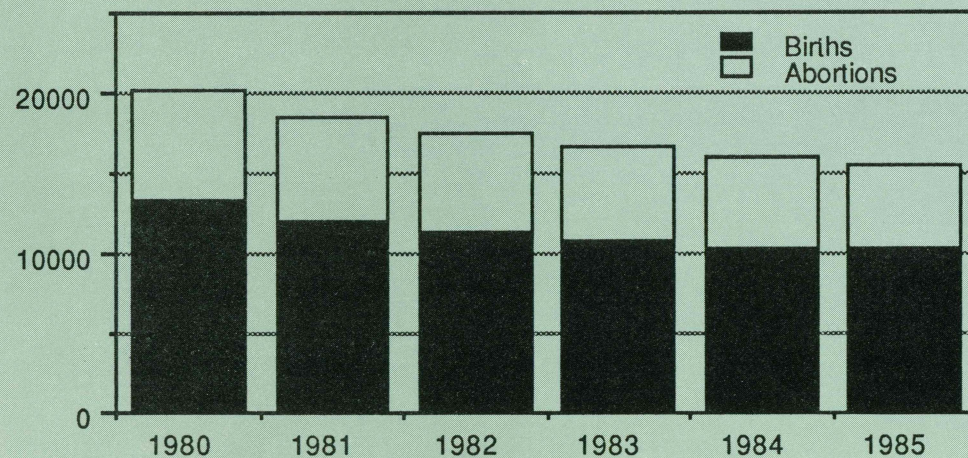
St. Louis and Kansas City, with the largest populations in the state and the greatest concentration of nonwhites, have the largest number of teen pregnancies. The Bootheel region actually has the highest rates of teen births but a smaller

...Bootheel region has the largest number of teen births outside of metropolitan areas...

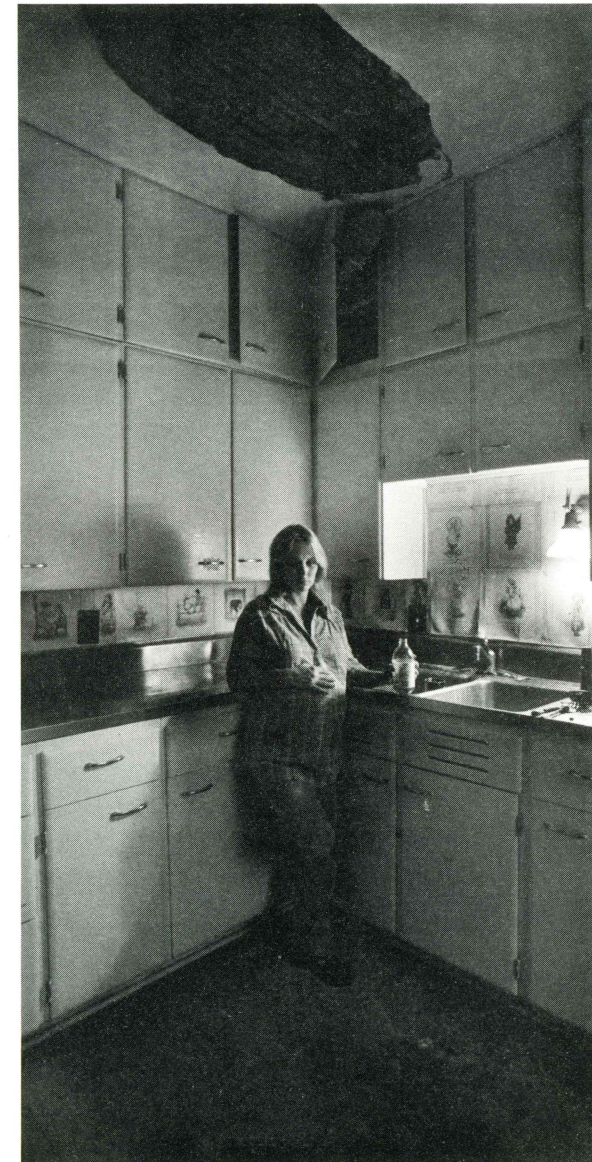
proportion of pregnancies are terminated. Although the Bootheel region has the largest number of teen births outside of metropolitan areas, teenage pregnancy is present in all counties and rural areas generally offer fewer services to these young mothers.



Teen Pregnancies in Missouri by Outcome



Source: Missouri Department of Health, State Center for Health Statistics





Consequences of Adolescent Childbearing

It is unlikely most adolescents truly comprehend the short and long term consequences associated with sexual activity, especially the unintended pregnancy. To start with, the adolescent must decide whether to give birth or have the pregnancy terminated. She must also decide whether to marry the father of the child when the option exists, and whether to continue her education. Plus, she must determine how to support her child.

These decisions have many long term consequences for the mother. She may face a decision on abortion; or she may settle for an unhappy marriage and probable divorce; or she may risk a lifetime of survival below the poverty level.

Research indicates that teen parents are more likely to:

- live in the inner-city areas;
- drop out of school;
- be unemployed;
- if employed, then probably work in a low-wage low-status job;
- give birth out-of-wedlock; and/or
- divorce or separate, if married.

Children of teen parents are more likely to:

- live in a broken or single parent home;
- have learning problems in school;

- live in poverty;
- be teenage parents themselves; and/or
- be dependent on public assistance as adults.

...by age 19, eight in ten males and seven in ten females are sexually active.

Teenage sexual activity

Sexual activity among teenagers has been on the rise in the United States. Between 1971 and 1979, sexual activity among American female teenagers increased 49 percent among whites and 14 percent among blacks. At present, by age 19, eight in ten males and seven in ten females are sexually active. By age 16, one-third of all white and one-half of all black unmarried girls have had sexual intercourse.⁸

While the number of sexually active teenagers has been rising, the average age of first intercourse in this country has been relatively stable at 16.2 years of age. Black women generally begin sexual activity at younger ages than white women, 15.5

...25 percent of sexually active girls had never used contraceptives and some 40 percent only use contraceptives sporadically.

years and 16.2 years respectively. Research indicates that the differences between races are more attributable to socioeconomic differences than racial differences.⁹

At the same time, adolescents remain unprepared to prevent pregnancies. Findings in a 1979 study of sexually active teenagers found that 25 percent of the girls had never used contraceptives and some 40 percent only use contraceptives sporadically. This is in spite of the fact that more than half of all premarital pregnancies occur within the first six months of the start of sexual activity. The increase in adolescent sexual activity, combined with ineffective use of contraceptives, has resulted in an increasing number of teenage pregnancies. Each year, over one million teenage pregnancies occur in the United States. It is estimated that 75 percent of these teen pregnancies are unintended. If these trends continue, 40 percent of today's 14-year-old girls will become pregnant

It is estimated that 75 percent of these teen pregnancies are unintended.

before the age of 20. Most will go on to become parents, whether they are socially and emotionally prepared or not.¹⁰

Maturity

Most of the problems related to teen pregnancy and parenting arise from the inability of adolescents to function as adults. Emotional immaturity, along with a fatalistic outlook on life, often characterizes teenage mothers. Teens typically live in the present. The possible consequences of sexual activity seem remote, and the responsibilities to potential offspring may not be perceived.

Also, the lack of short term negative effects of sexual activity contributes much to the understanding of the reasons why adolescent pregnancy is a problem despite the widespread availability of contraceptives. Teenagers frequently do not see themselves as able to control their socioeconomic status, and may see their social world as disenfranchised from the opportunities available to others in the higher

socioeconomic strata. Teens may feel that adolescents who have had children are better off since these mothers have obtained independence and the financial resources of public assistance.¹¹ From a teen's vantage point, a cuddly baby and a couple of hundred dollars per month may seem to be better than the other alternative of limited opportunities.



The Teen Mother

Birth rates to unmarried women of all ages have increased dramatically during

In 1950 only four percent of all births were out-of-wedlock. By 1982,...nearly 20 percent.

the last several decades. In 1950 only four percent of all births were out-of-wedlock. By 1982, this figure had risen to nearly 20 percent.¹²

Presently, approximately 31 percent of all first-born babies in the United States are conceived out-of-wedlock. The rate for white teens is about 60 percent while the rate for black teens exceeds 90 percent.¹³

When a teenager does become pregnant, her choices are to obtain an abortion or give birth. Most teens choose the latter option. In 1980, an estimated 48 percent of all pregnant teenagers gave birth, 39 percent obtained an abortion, and 13 percent miscarried.¹⁴

...more than 500,000 babies are born to teenage mothers in the United States each year. More than half of the teenage mothers will have a repeat pregnancy within two years.

Currently, more than 500,000 babies are born to teenage mothers in the United States each year. More than half of the teenage mothers will have a repeat preg-

nancy within two years.¹⁵ Among teenage women who had an out-of-wedlock pregnancy that resulted in a first birth in 1980-1981, only one in three married before the child was born. Only about 4 percent of the unmarried teenage mothers aged 15 to 19 release their babies for adoption; 96 percent attempt to raise their babies themselves.¹⁶

The social and economic context in which teenagers become mothers has changed in recent years. Prior to 1950, teenagers who became pregnant were likely to marry the baby's father. The marriage, while perhaps not ideal, was likely to result in a stable family situation. The father had a good chance of being employed. Many teenagers were equipped educationally and socially to take on adult responsibilities.

The unwed teenage mother today faces a dismal future. Not only is she often socially and emotionally unready for child-rearing, she often does not have a partner and breadwinner on which to rely. If she

If she does not finish high school, there is a 90 percent chance she will live in poverty.

does not finish high school, there is a 90 percent chance she will live in poverty. Even if she does finish high school, she will have a 75 percent chance of living in poverty if she remains single.¹⁷

It is estimated that 72 percent of all teen marriages end in divorce...

The prospects for a married teenager are not very promising either. Teenage marriages today are much less likely to offer the same stability than they did twenty years ago, particularly for minority youth. Many minority mothers will end up as

The teen marriage is twice as likely to end in separation or divorce as a marriage between older partners.

single parents, living in poverty. It is estimated that 72 percent of all teen marriages end in divorce, and 25 percent of these will occur within five years. The teen

marriage is twice as likely to end in separation or divorce as a marriage between older partners. In many cases there will be more than one child by the time of the separation.¹⁸ Women who had their first child as teenagers have twice as many children as other women and these children are likely to be raised in grim economic circumstances.¹⁹

Poverty and Public Assistance

While the problem of adolescent pregnancy is not limited to families living in poverty, there is a very strong relationship between the prevalence of teenage pregnancy and low socioeconomic status. Poverty tends to promote teenage pregnancy, which in turn, leads to low educational attainment, a probability for single parenthood, and further poverty. There is evidence that this cycle is often transmitted from one generation to the next.²⁰

Research indicates that pregnant adolescents come largely from lower socioeconomic families. In many instances, there is no cultural stigma attached to being an unwed teenage mother. Studies indicate that pregnancy may be the only path to recognition or status for young women with low socioeconomic status and poor school or economic performance.



Only one out of every two women who become mothers before they reach 18 complete high school...

Teen parenthood has a negative impact on the educational level that will be eventually obtained by both the mother and father. Only one out of every two women who become mothers before they reach 18 completes high school, as opposed to 96 percent of those who have children after they turn 20. Few mothers have the resources to enable them to continue school and make arrangements for child care. Teen fathers are 40 percent less likely to graduate from high school than older fathers.²¹

Teenage parents are more likely than non-teen parents to be employed in low-paying, low-status jobs — if they are able to find work at all. According to estimates, only one high school dropout in five is employed. Teenagers in general are subject to higher rates of unemployment.²²

In June 1986, the national unemployment rate was 7.1 percent. The unemployment rate for the 16-19 year-old age group was

19.9 percent, almost three times the national average. The unemployment rate for black teenagers was 41.9 percent, almost 6 times the national average. Many teenage parents who are not actively seeking work, because of the necessity to care for a child, are not included in these figures.²³

...one out of every five children in the U.S. lives in poverty. Over half of all poor children live in families headed by a single female.

According to a recent Census Bureau study, one out of every five children in the United States lives in poverty. Over half of all poor children live in families headed by a single female. Fifty percent of the children in families headed by white females live in poverty, while 70 percent of the children in black female headed families live in poverty.

Three out of four children of mothers who never married live in poverty.



Three out of four children of mothers who never married live in poverty. The combination of lack of education and single parenthood has sentenced many teen mothers and their children to almost certain poverty.²⁴

Associated with poverty is the dependence on government assistance in the form of food stamps, medical assistance, and/or monetary support through the Aid to Families with Dependent Children (AFDC) program.

When the precursor to AFDC was enacted in the 1930s, 88 percent of the families that received benefits were needy because the father had died. A 1980 study found that only three percent of AFDC children were paternal orphans. In 1983, 88 percent of the children in AFDC families had able-bodied, but absent, fathers.²⁵ Only

...88 percent of the children in AFDC families had able-bodied, but absent, fathers.

one single mother in ten below age 25 receives child support payments from the child's father. Those that do receive less than \$1,500 a year.²⁶ Furthermore, the



fathers of 47 percent of these children were not married to the child's mother.²⁷

It is estimated that 71 percent of all AFDC recipients under 30 had their first child as a teenager and that 30 percent of all Medicaid-funded births are to teenagers.²⁸ The Center for Population Options estimates that the direct financial cost of

...the direct financial cost of adolescent pregnancy to society is currently \$17 billion.

adolescent pregnancy to society is currently \$17 billion. Not only is there a high individual cost associated with teenage pregnancy, but also a high public cost.

Missouri Data

Missouri adolescents who become parents are subject to the same consequences as teens in other parts of the country. Many will drop out of school and attempt to support their child. Those who are looking for work will have a difficult time finding a job. When they do find a job, the chances are it will be a low paying one. They will also be subject to much higher rates of unemployment. Many will choose

public assistance because they cannot find work or because it offers a better option than working a minimum wage job while trying to support a child. For many, poverty will be a way of life.

While little data is available concerning the characteristics of adolescents who give birth in Missouri, information is available about two groups which contain a disproportionate number of teenagers who become pregnant: single parent households headed by a female and individuals 19 years-of-age and under who live in poverty.

...only 45 percent of female family heads living in poverty have completed high school.

A strong association exists between education and poverty. While 65.5 percent of all family heads living in poverty have completed high school, only 45 percent of female family heads living in poverty have completed high school.²⁹ Last school year, according to the Department of Secondary and Elementary Education, 14,062 Missouri children in grades 9-12 dropped out of school. It was estimated that less than half of the dropouts were females, but the

majority of the females who dropped out of school did so for reasons related to pregnancy. Many of these dropouts will end up as single heads of families, working in low paying jobs, unemployed, or dependent on public assistance.

Teens have the highest unemployment of any age group. Missouri's teenage unemployment is not significantly different from the national figures. For teens aged 16-19, the unemployment rate as of March, 1986 was 18.2 percent. And for high-risk black youth, the figures are truly alarming. While the national unemployment rate for white teens fell to 14.5 percent in March, 1986; black teens unemployment rose to 43.7 percent, more than three times the rate for white teens. In addition, the economic recovery of the past few years has largely bypassed teenagers. Teenagers who represent more than 17 percent of the unemployed received only one percent of all new jobs.³⁰

In 1979, 9.1 percent of Missouri families

Families headed by a single female under the age of 25 had a poverty rate of 54.8 percent.

lived in poverty. The poverty rate for families headed by a single female was 27 percent, three times as high as for all families. Families headed by a single female under the age of 25 had a poverty rate of 54.8 percent. Also, while 12.2 percent of all Missouri families were headed by a single female, 36.4 percent of the families living in poverty were headed by a female.³¹

...36.4 percent of the families living in poverty were headed by a female.

Approximately 15 percent of all children under the age of 18, living in families in 1979, lived below the poverty level. However, 44.1 percent of all children under the age of 18 living in families headed by a single female lived in poverty. For children under three living in families headed by a single female, 58.7 percent lived in poverty. This compares with 16.3 percent of all Missouri's children under three who lived in poverty.³²

For those adolescents who have to support a family and are unable to work, or cannot find jobs, public assistance may be the only alternative. Currently, approxi-

...53 percent of the AFDC caseload had their first child as a teenager. Over 28 percent had given birth before their 18th birthday.

mately seven percent of the Missouri AFDC caseload are teenage mothers; however 53 percent of the AFDC caseload had their first child as a teenager. Over 28 percent had given birth before their 18th birthday.

The Department of Social Services (DOSS) estimates that public assistance to teenagers giving birth exceeds \$225 million

...public assistance to teenagers giving birth exceeds \$225 million annually in Missouri.

annually in Missouri. Of that \$225 million, 55 percent goes to mothers who were 17 or younger when the first child was born.

Teenage public assistance cases are also more expensive than the average adult case for two reasons. First, the teenager

will be more likely to stay on public assistance longer than the average adult recipient. Second, much of the medical cost for childbirth and subsequent childbirth will be paid for by Medicaid.

A 1985 study by the Department of Social Services conservatively estimates that teenage mothers with a first out-of-wedlock child stayed on AFDC 6.5 months longer than the average adult recipient. Also, women who first become pregnant as teenagers tend to have twice as many children as other females, resulting in the need for prolonged assistance. In addition,

few unwed or separated teenage mothers receive child support from the father.

To illustrate the long term cost that can be associated with teen pregnancy, consider the case of a 16 year-old mother-to-be who will have two more children over the next two years and who has to depend on public assistance as her only means of support. Her medical expenses and the cost of the birth will be covered under the Medicaid program. After the baby is born she will be eligible for an AFDC grant, Food Stamps, and continued Medicaid coverage. In addition, she may receive



energy assistance payments to help with her utility bills, along with assistance through a variety of health and community based programs.

If this teenage mother stays on public assistance until her youngest child reaches 18 years of age, she will receive over \$200,000 in public assistance or an average of \$10,000 per year in AFDC, Food Stamps, Medicaid and energy assistance, in 1986 dollars based on current average utilization figures.

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While not all teenage mothers stay on public assistance for their entire life, teenage mothers are prone to longer lengths of stay and higher benefit utilization. Also,



...children of teenage mothers are more likely to become teen mothers themselves and continue the cycle.

children of teenage mothers are more likely to become teen mothers themselves and continue the cycle. A national study found that 82 percent of all mothers age 15 and under were children of teen mothers.³³



National Perspectives

Diaper bags and book bags — the two objects stand as symbols of one of the most complex social issues in America today: teenage pregnancy.

Teens often want to give their children more than they had as children but only a few will ever be able to do so.

Historically, the approach to “solving” the problem of teenage pregnancy nationwide has been piecemeal. This has often been due to a lack of a comprehensive policy at any level of government. The issue is further complicated by the diversity of factors, consequences and service needs associated with adolescent pregnancy and the often unconnected nature of program development which crosses systems.

Recent attention focused on the problem of adolescent pregnancy has served as a catalyst to the states to find effective ways to address one of our nation’s most distressing social issues — teenage pregnancy. States are beginning to examine the problem of adolescent pregnancy and search for effective state and local initiatives in this area.

The purpose of this chapter is to attempt to develop framework for advancing the study of what is being done in other states

and what can be done to build on those experiences. It does not attempt to be a comprehensive or all-inclusive listing of specific programs, nor is it an endorsement of specific programs. As information is gathered and analyzed, those committed to addressing this problem may move closer to a solution.

It is clear from our study that currently there is no focused approach to solving the complex problems of teen pregnancy at any level of government.

It is clear from our study that currently there is no focused approach to solving the complex problems of teen pregnancy at any level of government. The efforts that do exist are too few, uncoordinated, and lack sufficient support, but they do serve as starting points. States must learn from each other. They will prove to be each other’s best teachers. Successful programs must be discovered and duplicated.

Because of the complexity of the issues relating to teenage pregnancy, states have begun to address the problem through the



development of centralized task forces on a statewide level. These task forces bring together all the diverse groups that are interested in this problem. The task forces often include state agencies representing education, public health, public welfare, Medicaid; private agencies such as the United Way, Salvation Army, YMCA, March of Dimes, and Planned Parenthood; interest groups representing client groups, churches, PTAs, the League of Women Voters, and legislators.

These statewide coalitions can serve to coordinate existing services; study the problem and develop new coordination possibilities; lobby for policy, budgetary, and legislative initiatives; and advocate for the establishment of local coalitions.



During the past few years there have been no fewer than twenty executive task forces established by government to study the prevention of adolescent pregnancy and problems associated with teen parenting. In addition, five state legislatures have formed task forces and in four states — Missouri, New Mexico, New York and Connecticut — there are both statutory and executive task forces.

There are a few goals on which states tend to focus when discussing their programs:

- reduce the incidence and rate of teenage pregnancies;
- reduce the incidence of abortion among adolescents;
- improve the decision-making and communication skills of adolescents to better prepare them for the adult world;
- decrease other risk-taking behavior;
- decrease high school dropout rates; and
- reduce the high and continuing costs of welfare, health care, and social services.

In March 1986, the directors of the Missouri Department of Social Services and the Missouri Department of Health —on behalf of the “Governor’s Interagency

Working Group on Adolescent Pregnancy” — sent a letter to the chiefs-of-staff of the state governors to survey what roles the states had assumed in dealing with the problems that result from adolescent pregnancy and parenthood.

The Interagency Working Group (IWG) was especially interested in learning about any efforts that were being made in the states with regard to vocational training and employment-related services. In particular, the IWG was interested in learning whether any funds from such federal programs as the Job Training Partnership Act (JTPA), the Carl Perkins Vocational Education Act, the Work Incentive Program (WIN), or the Community Services Block Grant (CSBG) — and/or whether any state funds — were being used to target employment or vocational-related services for teenage parents.

The Carl Perkins Vocational Education Act provides an opportunity for local school districts to provide to single parents a comprehensive educational program of services, including educational assessment; career decision making; basic literacy instruction; support services; tuition and child care. The goal of Carl Perkins Act is to make vocational education and training programs more accessible to single parents

by assisting them with related support services.

Forty-nine states and the District of Columbia responded to the survey. The returned information was best summed up by the Minnesota response: "Initiatives for teen parents have generally addressed the social service, medical, and educational needs of the teen parent. There has not been a concentrated focus on employment and vocational-related services for this target population." In a few instances, we are aware of more recent state actions or studies and have included that information.

Sixteen projects were funded through the Carl Perkins Vocational Education Act in **Wisconsin** during FY-86. The total cost of the sixteen projects was \$551,500. Among the projects funded were the CESA 7 Project and West Bend Project.

The CESA 7 Project developed two twenty-minute videotape programs for use on instructional television and local schools. The tapes encourage young single parents to prepare for economic self-sufficiency by discussing employment options, education and training programs, nontraditional career options, and special issues facing teen parents trying to attain marketable skills.



The West Bend Project provides job training, child care and adult role models who act as resources for students. Employability and job skills courses are offered for credit and each student must complete four on-site observations (one must be a nontraditional job and one must be with a model parent who is currently balancing the dual roles of parent and wage earner).

In **Colorado**, the Governor's Job Training Office (which administers JTPA funds) and the State Board of Community Colleges (which administers Carl Perkins funds) have signed a cooperative agreement which funds the Colorado Rural Teen Parent Project. The project costs for FY-86 were \$62,000. The program operates in three rural counties and provides services that include academic instruction, vocational training, and job placement. The project is funded with \$32,000 from JTPA and \$30,000 from the Carl Perkins Act.

The State of **Connecticut** has recently begun operating a Work Incentive (WIN) demonstration program for AFDC applicants and recipients. The WIN demonstration project, called The Job Connection, emphasizes education, training, and support services that will lead to long-term self-sufficiency.

Registrants can participate in a wide range of programs including adult basic education, English as a second language, high school instruction, GED preparation, vocational-technical school, community college, state technical college, and JTPA. Participants in education and training can receive assistance with child care and other training-related expenses.

To address the needs of teen parents with young children and encourage them to participate in the program, the Connecticut Department of Income Maintenance plans to place a special social worker in each of their three largest urban offices to form support groups targeted to adolescent parents. The groups — which may actually meet outside local offices in favor of community centers, churches, or housing projects — will focus on work and training opportunities, self-esteem, child care and parenting issues.

Delaware uses Carl Perkins funds specifically for three programs: The Career Exploration Program (single teen project) sponsored by the United Way of Wilmington; the Teen Parent Program sponsored by the Colonial School District — William Penn High School, and the Men's Work/Women's Work/Resources for the Young Parent, sponsored by the

Wilmington YMCA.

The Teen Parent Program is designed to assist teenage parents while they are in school by providing support and career counseling, employability training, child care assistance, and job placement assistance. Participants are selected based on referrals from counseling staff and nurses at William Penn High School. Students in the program have access to all school personnel and services throughout their attendance at the high school.

Men's Work/Women's Work/Resources for the Young Parent is a project focusing on the issue of sexual stereotyping in employment and promotes expanded horizons for both young men and young women.

Illinois' Parents Too Soon (PTS) initiative is aimed at both prevention of adolescent pregnancies and helping parents

According to Illinois officials, vocational services are among the most critical in helping teens in the motivation to postpone early parenthood.

cope with the responsibilities of parenthood. A variety of medical, social and vocational education services are offered by 125 local agencies funded through the initiative. According to Illinois officials, vocational services are among the most critical in helping teens gain the motivation to postpone early parenthood. The PTS initiative has employed several models for providing that training. From the outset of the initiative, the program has been funded to provide employability skills to teens on welfare.

Under the Young Parents Program, the Illinois Department of Public Aid offers vocational services. Workshops for teenage AFDC recipients cover the topics of: Planning for the Future, the World of Work, Vocational Education Opportunities, Personal and Family Health, Parenting Skills, and Self Esteem Development. Participants take part in a self-support program based on their individual needs. Key components include job club, independent job search, education and training, and English as a second language. Support services may be provided, including payments for child care and transportation. The staff works to maintain a current file of appropriate referral resources and follows participants for six months after they

Services Provided in Five Reported Types of Pregnancy Prevention Programs*

Program type	Typically included	Possibly included
Sexuality education	Class instruction in puberty and reproduction	Discussion of family life, sex roles, interpersonal relationships, or family planning
Interpersonal values	Outreach workshops and seminars on peer pressure, interpersonal relationships, and family communication	Assertiveness training, education for self-esteem, or ongoing peer support groups
Parents as educators programs	Outreach workshops and seminars on adolescent development, peer pressure, and family communication	Sexuality education material provided to teenagers
Family planning clinics	Physical exams, contraceptive information and supplies, and pregnancy testing and counseling	Community education and outreach or special education and counseling for teenagers or their parents
Comprehensive teenage health clinics	Routine health care, physical exams, health education, and counseling	Substance abuse programs, contraceptive services, or prenatal health care

* 1986 GAO Brief Report on Teenage Pregnancy

receive employment.

The Illinois Department of Adult Vocational and Technical Education has created 59 education/employment planning grant districts with Carl Perkins Vocational Education Act funds. These districts are required to establish networks with local education, social and economic services to develop plans for vocational education

that will determine curriculum needs, cooperative planning, and develop a joint system of policy and procedure for vocational education.

These districts are coordinated with twelve career guidance centers which survey the regional areas and determine local occupational and educational information, including labor market trends.

They develop expertise in providing vocational guidance services for a variety of special populations, including teen parents.

The Perkins monies for single parents and homemakers are also being linked with the Parents Too Soon initiative. A new teenage, single parent initiative — Education for Employment — is now getting underway. It is a cooperative arrangement with the State Board of Education, the Parents Too Soon initiative, the Ounce of Prevention Funds, and the Illinois Caucus on Teenage Pregnancy to develop and integrate the system to enhance the employability options of teen single parents.

In **Vermont**, the Addison County Parent/Child Center provides job readiness training for teen parents. The Center, recognized nationally for its work on teen pregnancy prevention projects, is involved in a "parent stipend program" which trains teen parents to adapt to the work world as well as learn specific job skills using the parent child center as a work setting. Teen parents are then placed in jobs in their communities.

Programs responding to concerns about teenage pregnancy have tried two general approaches, according to both IWG survey

results and July 1986 General Accounting Office (GAO) "Briefing Report on Teenage Pregnancy." The first approach represents efforts to prevent teenage pregnancy. The second approach provides services to teenagers who became pregnant and to parenting teens.

A GAO review of the program literature, which included surveys of state and local government agencies, uncovered a wide variety of approaches to preventing teen pregnancy and providing assistance to teenagers who are pregnant or mothers.

Although many promising state and local programs were identified, the evidence of their effectiveness was lacking or ambiguous. There is a severe lack of concrete, proven models and concepts to achieve teen pregnancy prevention and provide needed services to adolescent parents.

GAO said, "There were too few adequate studies and too much diversity in the sets of services they represent to permit an independent evaluation of the effectiveness of specific service components."

Services Provided in Five Reported Types of Pregnancy/Postpregnancy Programs*

Program type	Typically included	Possibly included
Perinatal health care and parenting education	Medical exams and care; information on pregnancy, childbirth, and infant health care; and nutritional advice and supplements	Family planning services, information on child growth and development, intensive training in mother-child interaction, or social service referrals
Residential care	Residential care for pregnant teenagers, prenatal care and childbirth education, and individual and group counseling	Arrangements to continue education, family planning services, or residential services for teenage mothers and their children
Alternative school	Academic instruction (at home or in a separate building) and referrals for perinatal health care and parenting education	Family planning services, group counseling, or special childbirth and parenting classes for students remaining in regular classes
Social services with referrals	Outreach, individual or group counseling, and referrals for health and education services	Life-skills training, preparation for general equivalency diploma, or vocational assistance
Comprehensive services	Prenatal health care and parenting education, arrangements to continue education, group counseling, referral using a case-management system	Vocational assistance, family planning services, child care, or single assignments of staff

* 1986 GAO Briefing Report on Teenage Pregnancy

Sound evaluation is essential. Support for innovative programs is certainly not a new concept, but the GAO review of prior evaluations shows that, despite a substantial investment of effort, there is little

credible evidence on how well, if at all, programs work. Deciding whether a program model is promising enough to be considered by other state and local agencies depends on sound evaluative evidence.

GAO said, "There were too few adequate studies and too much diversity in the sets of services they represent to permit an independent evaluation of the effectiveness of specific service components."

The **Texas** Department of Community Affairs is making research and evaluation a part of the Teen Parent Initiative (TPI) from its outset. The role of the research and development staff will be to provide information on an ongoing basis to the TPI project director, program staff, and the TPI interagency council so that they can make informed decisions about the initiative as it develops. The purpose of TPI is to coordinate resources at the state level that will support the efforts of community-based programs.

Given the emphasis on identifying whether programs work, why they work, and for whom they work, the following evaluation considerations should be addressed, according to the GAO:

- Are innovative services or other factors responsible for intended changes in important outcomes? Evaluation designs must include a basis for comparison. This should be obtained from analysis of data on comparable individuals, who do not receive the innovative services, or analysis of time-series data. This does not mean that individuals in comparison groups must be denied services. They could be provided "customary" services that do not include all the features of the innovative program;
- Describe the innovative program and its components. Client characteristics and type and amount of services should be detailed enough to allow for implementation in other service settings;
- Outcome measures should be relevant to the specific objectives of the innovative projects. Comparable data collected across projects should facilitate between-project comparisons;
- The measurement of intermediate and long-range outcomes should be scheduled to ensure that sufficient time elapses for program outcomes to be demonstrated;
- Reported results should provide suffi-

ent detail to allow readers to assess the validity and integrity of the conclusions.

The IWG also found that very few reports describe their program costs and those that did use different calculations. There is little point in discussing how to increase the availability of prevention programs when we do not even know if those programs work.

It is the IWG's opinion that the public is not going to support programs without evidence that such efforts have been successful. Given the volatile and controversial nature of many programs, success is going to be variously defined and ascribed.

The basic flaw in the way comprehensive service programs were conceptualized and funded is that it was assumed that basic resources already existed in most communities and that relatively small grants would provide the missing pieces to integrate the services. Lacking were:

- adequate funding for prevention services — material resources for such basic services as day care and counseling;
- individuals with the managerial ability to bring together agencies with different missions and philosophies; and

- community acceptance and political support.

The State of **Washington** did make community acceptance and political support a part of their demonstration projects.

The State of Washington's Division of Health funds demonstration Adolescent Pregnancy Projects in four counties identified with high rates of teen pregnancies. Maternal-Child Health Block Grant funds have been allocated for three years in Yakima, Grant, Chelan-Douglas, and Grays Harbor Counties. Each county initiated a community task force comprised of representatives from local agencies that had concerns about or could provide services to pregnant and parenting teens. A prerequisite for funding stipulated that local networking between private and public resources be coordinated by the project. Project workers perform as case-managers for each client providing referral, follow-up, support, and advocacy as she progresses through her pregnancy and the first two years of parenting.

The goal of these demonstration projects is to enable pregnant and parenting adolescents, ages 17 and under, to increase

their independence in caring for themselves and their children.

Each county has unique differences in resources and barriers to care; subsequently, each project has been attempting to creatively address local issues and utilize the particular local strengths and supports. Although each project has similarities in providing basic case management services, each has a slightly different emphasis.

An extensive evaluation method, with two major components to document effectiveness of the projects, is being implemented. The first component will describe client outcomes to show movement from dependence to independence in the area of financial, educational, health and social situations. The second will describe local processes in regard to community networking of existing resources and identification of needed services to pregnant and parenting teens.

Demonstration projects are not enough. Eventually federal and state governments must decide whether the projects are achieving sufficient success to warrant duplication elsewhere.

In the future, more attention must be given to:

- funding — currently funding is directed at costly crisis situations and terminal care rather than the more cost-effective prevention measures;
- day care services;
- young mothers — job training and employment programs stressing completion of high school, and ideally providing for further education, either through skills training or post-secondary education; and
- preparing and sharing with other states reports of successful models and proposed programs.

According to a 1986 report published by the House Select Committee on Children, Youth and Families, twenty-six states responding to a committee survey indicated that existing services in their states were inadequate for addressing the needs of pregnant and parenting teens.

In 1982, the **Florida** legislature included language in the *Implementation and Administration of the General Appropriations Act* which placed educational programs for pregnant, married and parenting students under the educational alternative program category. The legislature continued to include this language

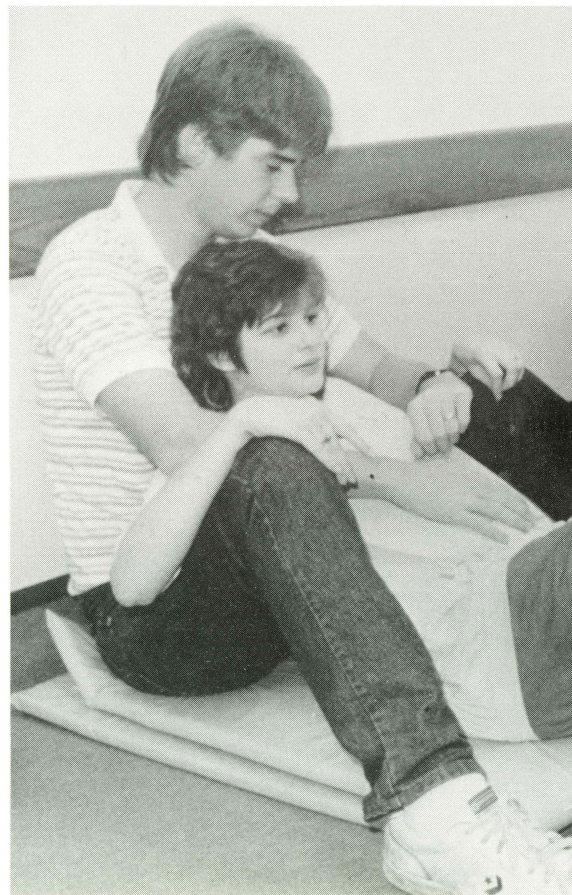
until it enacted the Dropout Prevention Act in 1986. The legislation defines "teenage parent programs" as "educational programs which are designed to provide a specialized curriculum and other services to meet the needs of students who are pregnant or students who are parents."

In Florida, education programs for pregnant students generate "weighted" state funds. This means that school districts receive more money per student for these programs than for students in regular classes. The weighted factor is 1.6 times the basic amount for each student which helps to offset the additional costs of these programs.

During the 1985-86 school year, 19 Florida school districts offered special programs for students who are married or who are parents. Most of these programs are housed in vocational schools, alternative schools, private agencies, and other locations apart from regular schools. Centers range in size from one to twenty teachers. Some programs serve elementary, middle and high school students who have become pregnant.

Barriers to serving more students in alternative education programs are similar around the country: number of students

affected, geography, philosophy, facilities, and funding. For example, although the incidence of teenage pregnancy in small school districts may be high, the total number of students may be too low in any one year to support special programs. The geographic distances between population



areas in rural districts is often too great to make transportation of students to a central location feasible. And simply the philosophy of some school boards may be opposed to providing additional educational services to students who are pregnant or who are parents.

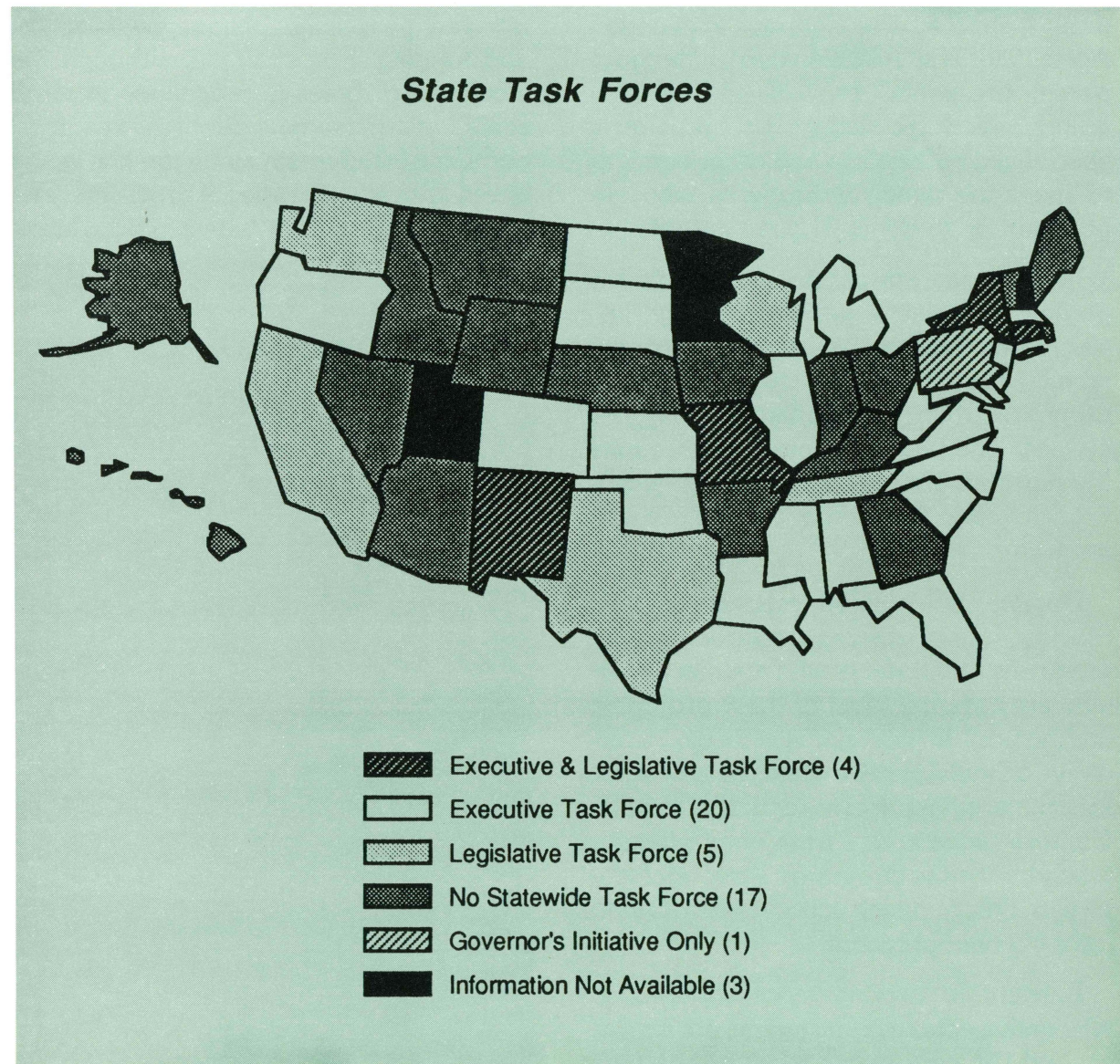
In addition to alternative education programs, there are about thirty-five school-based clinics operating in at least fourteen cities in the United States, according to information supplied by the Children's Defense Fund in April 1986.

While each school-based clinic is unique in some respects, all share several basic characteristics: provision of comprehensive primary health care, location in a school serving predominantly low-income youths, requirement of parental consent for use of any clinic service, and operation independent from the school system.

While each school-based clinic is unique in some respects, all share several basic characteristics: provision of comprehensive primary health care, location in a school serving predominantly low-income youths, requirement of parental consent for use of any clinic service, and operation independent from the school system.

In **Maryland**, "Character Education" fosters responsible personal and citizenship behavior. In September 1985, the final report of the Governor's Task Force on Teen Pregnancy recommended "that the Governor, the Maryland State Board of Education, and local educational agencies support the development and implementation of character education programs." To date, Baltimore County and Baltimore City have taken the lead in initiating character education programs in Maryland.

A special project in **Alabama** is the Adolescent Life Project of the Charles Henderson Child Health Center. The Center is a private, non-profit ambulatory health care facility. This rural adolescent pregnancy care and prevention program is organized into three operational components, including health services, social services, and educational and community outreach. The program provides medical



counseling and educational services to pregnant and parenting adolescents. Counseling and educational services are provided for all of the school population.

All students are served through educational school health nursing services, counseling services, and the lifestyles/family life educational curriculum. Program nurses stationed at each of the schools serving adolescents provide on-the-scene access for all students. Fully equipped clinics have been established at each of the schools.

This project is operated under a contract with the School of Public Health at the University of Alabama at Birmingham and includes an evaluation component. The evaluation generally consists of measuring the impact of the project on reducing the rate of first and repeat pregnancies, and assessing the degree to which objectives and goals of the program have been met.

The case manager model used by the Teenage Pregnancy and Parenting (TAPP) Project in **San Francisco** has been very successful in reaching out to pregnant and parenting teens and ensuring that they identify the services and supports they need and use them consistently for as long as needed. The TAPP Project has shown improvements in birth outcomes, decreases

in the number of repeat births, and increases in the number of teens who continue in school. The case manager's role has been an essential factor in these successes.

The case management model, borrowed from the fields of mental health and developmental disabilities, can be cost effective because it allows early identification of needs, prevents problems from intensifying, and avoids duplication in the delivery of services. It requires skilled staff who are knowledgeable about teens and community resources and who are sensitive to their clients' needs.

The case manager, knowing the client's special needs, can function both as counselor and broker for the client. To become self-sufficient, a teen must learn to find and appropriately use such services as health care, family planning, after-school

activities, and job training. The case manager's continuing involvement with the teen enables the manager to assist clients in career and life planning. The manager is also helpful in connecting the teens to services they may be reluctant to seek on their own, such as family planning or early prenatal care.



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The State Role: Policy Options

Most of the opportunities for prevention of teenage pregnancy are locally based. State government can, however, play an invaluable role in stimulating, facilitating, and supporting local actions. State government can help prevent teenage pregnancy and parenthood through:

- public articulation of the issue of teenage pregnancy;
- setting priorities;
- statutory, regulatory, and policy changes to cover successful approaches under existing state programs;
- assistance in coordinating the use of multiple state programs to support

- local initiatives;
- financial support for local prevention efforts;
- technical assistance to local providers establishing and operating prevention programs;
- public information services about successful strategies;

- connecting local providers with information, funding, and additional technical assistance; and
- documentation of the results of programs designed to reduce teenage pregnancy.

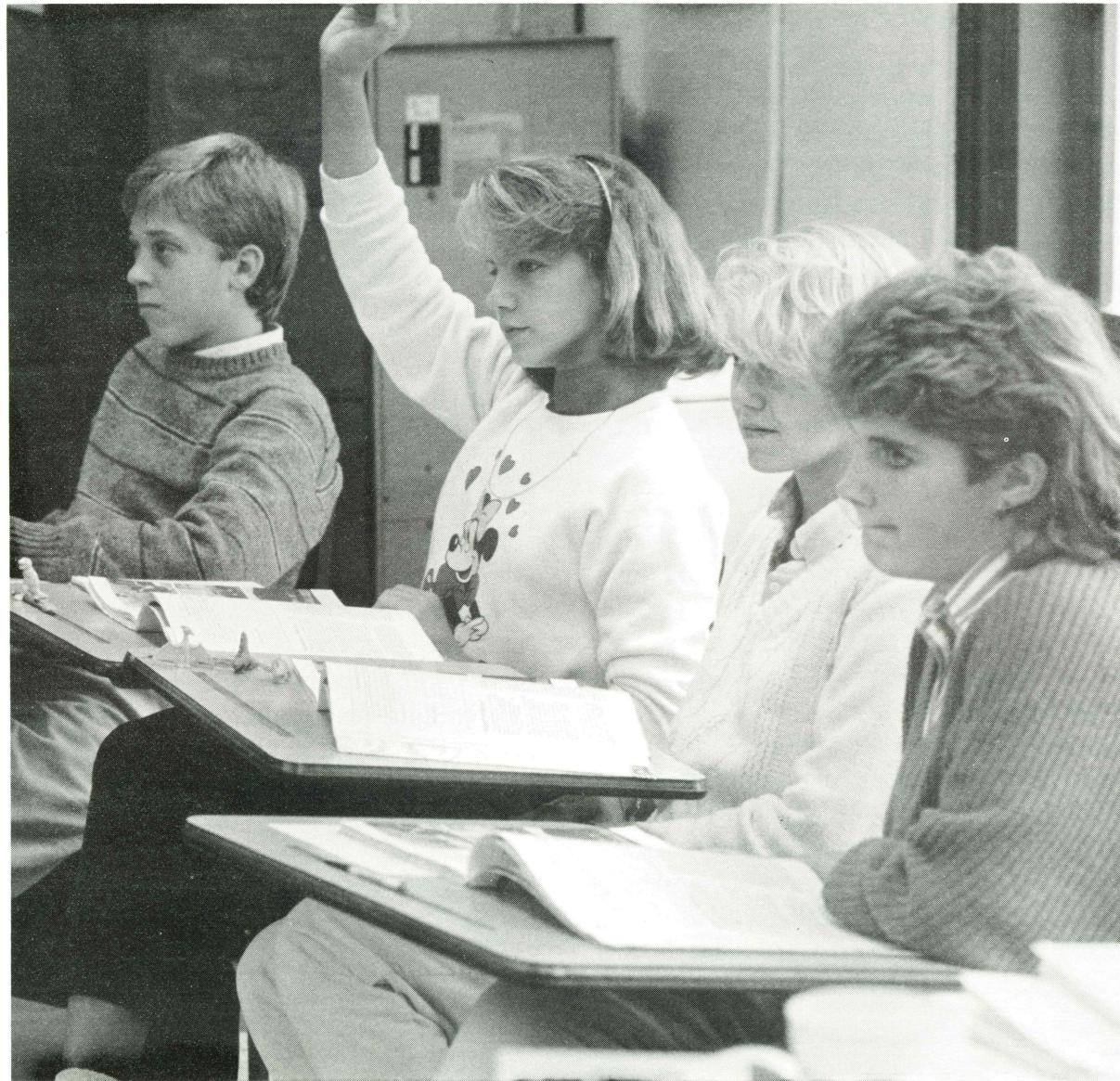




Missouri Perspectives

As in most states, the variety of support and preventive services provided by state agencies are neither coordinated to address teen pregnancy and parenting as a target population, nor restricted to that population. This lack of coordination is, in fact, a contributing factor to the establishment of the Interagency Working Group by Governor Ashcroft. His charge to the Working Group was to both propose new initiatives to address the issues surrounding teen pregnancy and parenting and to strengthen the coordination of the many services available.

This is not to say that there are not programs directly targeted to teen pregnancy prevention or to assist adolescent mothers. In fact, a number of programs are underway in Missouri, some of which are partially supported by state or federal funds and others which are privately funded. In the course of the analysis, a number of such projects were brought to the attention of the Working Group. We applaud the efforts of communities, churches, and other groups attempting to address these issues. But, since the charge to the Working Group was to focus on direct state services, any assessment of these programs fell beyond the scope of the Working Group's efforts.



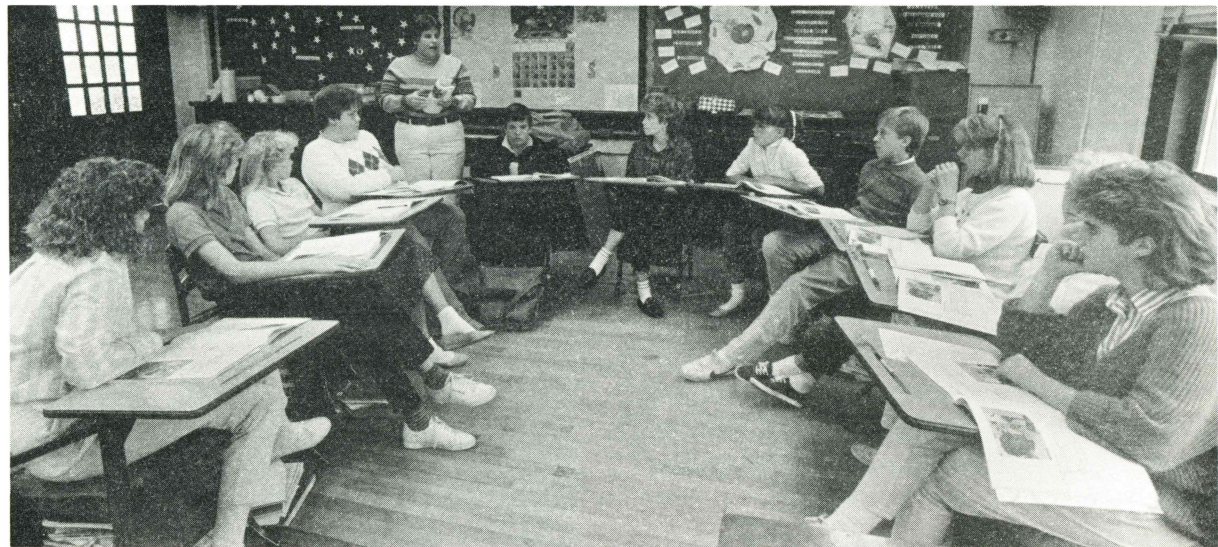
Public School Program Offerings

Topics relative to the teenage pregnancy issue may be integrated into school curriculum in such areas as science, home economics, health, physical education, and health occupations curricula. Home economics and health programs can be documented as having impact on the teenage pregnancy issue.

Of the state's 545 public school districts, 386 have vocational home economics programs. The curriculum focuses on the family, with the goal of improving family life and the lives of individual family members.

At least five high school courses within vocational home economics programs include content relevant to the teenage pregnancy issue. In 1985-86, a total of 34,200 Missouri students — including 9,122 male students — were enrolled in these courses dealing with parenthood, contemporary living, family and individual health, and child development. One area of emphasis in these courses and exploratory home economics is self-appreciation and development of positive self-concept, which research indicates is a key to prevention of teenage pregnancy.

Junior high/middle school exploratory home economics is taught in all of the 185



school districts classified as AAA by the Department of Elementary and Secondary Education for their academic programs. An increasing number of school districts have middle school programs which enroll all students in a quarter or trimester rotation of offerings. One of these offerings is typically home economics. Human development and the family, and family and individual health competencies, have been identified for exploratory home economics.

The Department's home economics education staff also coordinates state-level activities of the Future Homemakers of America, the vocational organization for

home economics students. The organization sponsors a national peer education project, "Families and Futures," to help young people make informed, responsible decisions about individual and family health. Through the project, teen members share important information on teenage pregnancy and other topics with their peers. Since the project was started in 1975, it has reached an estimated six million teens nationally.

State curriculum guidelines require each local school district to develop a comprehensive school health instruction program. Reproduction and family planning is one of the recommended health instructional

areas. The Department has provided each school district with "A Guide for Developing a Comprehensive K-12 School Health Instruction Program." The guide is divided into nine conceptual areas, one of which is "Family Life and Sex Education" suggested concepts, objectives, teaching strategies and assessment methods for grades K-12 are included in the guide.

Several Missouri districts have implemented exemplary health education programs. Less than five percent of the school districts have not developed a health program.

In addition, some school districts have identified teenage pregnancy as an issue which requires direct action. These school districts have designed special programs to help prevent teenage pregnancy and/or assist pregnant teenagers and adolescent parents.

Early Childhood Education

State funds authorized to Missouri public schools through the 1984 Early Childhood Development Act provide a training and support system for all families, including teen parents, with children under the age of three. The program, Parents as Teachers (PAT), is predicated on the assumption

that parents are the primary and most influential teachers of their children. As such, they need, deserve and can benefit from timely, practical information and support in this important role.

The PAT curriculum, validated as being remarkably successful in an independent evaluation, focuses on the foundations of all later learning — curiosity, intellectual, social, and language development of young children. Services are delivered through several components. Periodic monitoring of a child's development by parent educators and parents ensure that youngsters will not go through the first three years of life with an undetected educational delay. Personalized home visits, delivered by trained parent educators, are designed to provide specific information on child development, assist parents in observing their children, and teach ways of encouraging development and responding to children's cues. Small group meetings with parents of similarly aged children enable families to share common concerns, frustrations, and successes in the rearing and teaching of their children. Finally, a referral network locates services for parents with needs beyond the program's scope, such as financial or medical assistance.

This primary prevention program — the only state-funded program of its kind — is expected to: maximize the potential of participating children, thus eliminating or minimizing needless delays; reduce the stress of parenting that can often lead to child abuse; and better link needs with existing services. Interested parents can contact their local school district for additional information.

Homebound Services

Homebound educational services are provided to students who are not able to attend the regular public school. Any student through the age of twenty who is pregnant may receive homebound instruction during a period of six weeks prior to and six weeks after delivery. If there are medical complications, homebound instruction can be continued with appropriate authorization by the Department of Elementary and Secondary Education.

Parents of pregnant students and the pregnant student work with the authorized local public school official to complete the homebound services application form. The teenager's physician signs the homebound application to attest to the need for homebound services. In turn, the local public school district, or local special

district, sends the physician-approved homebound application to the Director of Special Education for approval. If the student needs more services than the standard six weeks prior to and after delivery, an extension may be granted by the Director of Special Education.

Homebound instruction is provided for at least five hours each week. This allows the student to be counted as a served student for the purposes of generating homebound aid and for enumeration required by attendance reports in the public schools. The function of the homebound instruction is to assure that each student retains continuity in instruction during the pregnancy period so that education can be maintained to help the student persist to graduation.

Vocational Education Special Programs

The Division of Vocational and Adult Education, Department of Elementary and Secondary Education, is authorized to administer the Carl D. Perkins Vocational Education Act of 1984 funds. Part of these funds are designated for programs, services, and activities for girls and women aged 14 through 25 which enable the participants to support themselves and

their families.

The division allocates funds to sixty-eight institutions in the state. Fifty-eight area vocational-technical schools and ten community college districts each receive an allocation and submit a plan to provide a program of services.

A broad range of educational services may be provided related to vocational education programs. These services may include outreach; orientation and pre-enrollment activities with a focus on assessment and career planning; tuition assistance for training program; basic

literacy instruction; instruction for supplemental support services on a variety of topics, such as self-concept building, family-work relationships, job search training, job readiness training, and dependent care for children.

The purpose of these Carl Perkins monies is to make vocational education and training more available to single parents. The goal is to provide the training necessary to obtain a marketable skill and to maintain a career sufficient to support themselves and their families. This goal extends beyond job-entry level training.



A particular focus is placed on career awareness activities of the projected job market of the future. These activities explore the new technologies, new and emerging areas, and the nontraditional occupations for women. Educational guidance and counseling services are provided to assist the single parents to develop a career and educational plan to achieve their goals.

Women in secondary schools are provided services through the 58 area vocational-technical schools. Women not in school are served by a network of seven regional and two large district centers, in addition to the network of thirteen community colleges. These programs provide a comprehensive educational program on vocational careers and related services.

Adult Basic Education

Adult Basic Education (ABE) programs enable adults to acquire basic skills necessary to function in society by making available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

Adults 16 years and older may take advantage of basic education opportunities



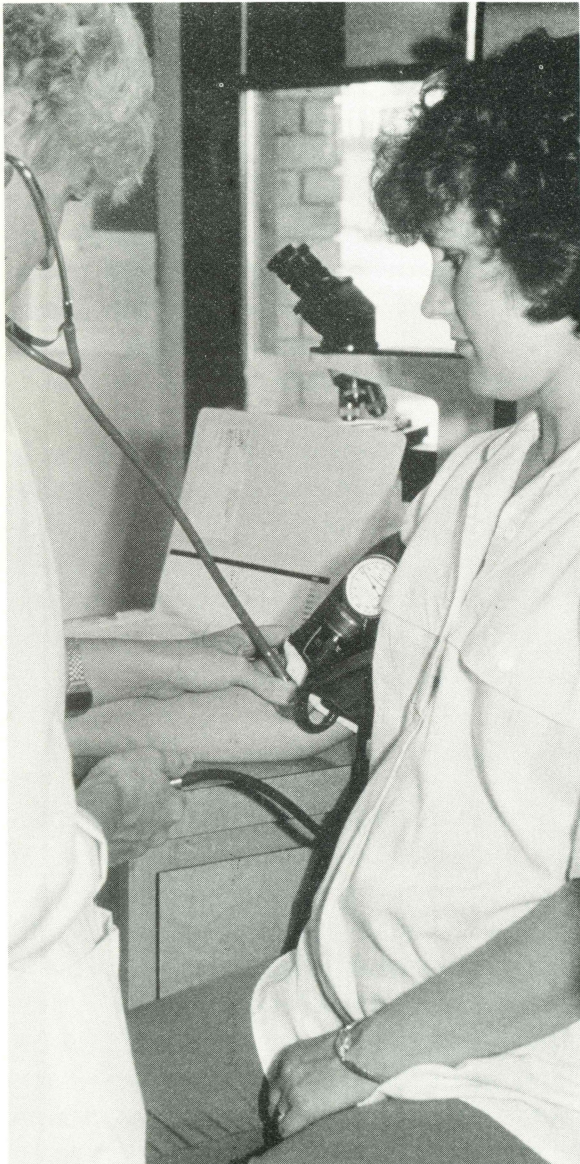
by enrolling in any one of 41 ABE programs which are conveniently located and provided free of charge around the state.

Many teenage parents do not complete their high school education. ABE provides a variety of basic education skills and services for the teenage parents which enable them to complete their high school education by earning a high school equivalency certificate.

Some programs in urban areas provide child care and transportation for young parents. Others provide ABE classes specifically for pregnant teenagers whereby they are not only able to study for high school completion but also learn life-coping skills and consumer education.

Prenatal Care

The State of Missouri in FY-86 appropriated \$600,000 to the Department of Health to provide prenatal care throughout the state. The Department contracts with local and city health departments to provide prenatal care clinics for women who otherwise would receive limited or no prenatal care. Most local and city health departments offer this service to any woman in need of prenatal care.



Women participating in prenatal programs receive health services necessary for adequate prenatal care and optimal pregnancy outcome. Services include nutrition education and assistance, comprehensive medical care, assistance in planning for labor and delivery, high-risk assessment, referral and follow-up, home visits, and individual counseling.

Pregnant adolescents are encouraged to participate in the prenatal clinics offered throughout the state. However, eligibility for receiving services is not based on age. Of the 5,059 women who received services in FY-86, 1,107 — 21.8 percent — clients were less than 18 years of age.

Of the 10,068 births to women less than 20 years of age in FY-86, 59 percent received adequate prenatal care, 38.6 percent were identified as having inadequate prenatal care, and 2.5 percent received no prenatal care. Adequate prenatal care is one of the most significant factors contributing to a healthy, robust baby.

There exists a small number of state and federally funded prenatal care programs targeted solely to adolescents in Missouri. These programs are offered primarily in urban areas which have the larger number

of clients to make these programs economically feasible.

Family Planning

Federal funding through the Title X Block Grant provides comprehensive family planning, medical services, and social services to high-risk, low-income, and minority individuals. Specific services include pregnancy testing, contraceptive services, pap smear screening, and the diagnosis and treatment of sexually transmitted diseases.

Family planning is based on the theory that education plays an important role in the creation of a family. Medical information provided to clinic users helps them to make more informed choices and to become active participants in their medical care. In addition, the type of medical care and education offered in family planning clinics contributes to healthy lifestyles and habits.

In FY-86, of the 19,414 clients served, 34 percent (6,626) were adolescents. There are clinics available specifically for teens that recognize the special developmental and psychosocial needs of the sexually active adolescent. Family planning clinics are available in most areas.

Primary Pregnancy Prevention

The primary pregnancy prevention projects in Missouri operate under the principle that the solution to adolescent pregnancy lies in postponing sexual involvement. Actual programs vary in curriculum and in age groups served. However, most programs train teenagers to educate their peers on health issues. Their primary purpose is to counter social and peer pressures that encourage sexual activity.

Similar programs have also been designed to delay repeat pregnancies to adolescents. These programs are based on the fact that those problems associated with adolescent parenthood intensify with additional children. Many teens often have more than one child before they reach age 20.

Mental Health Services

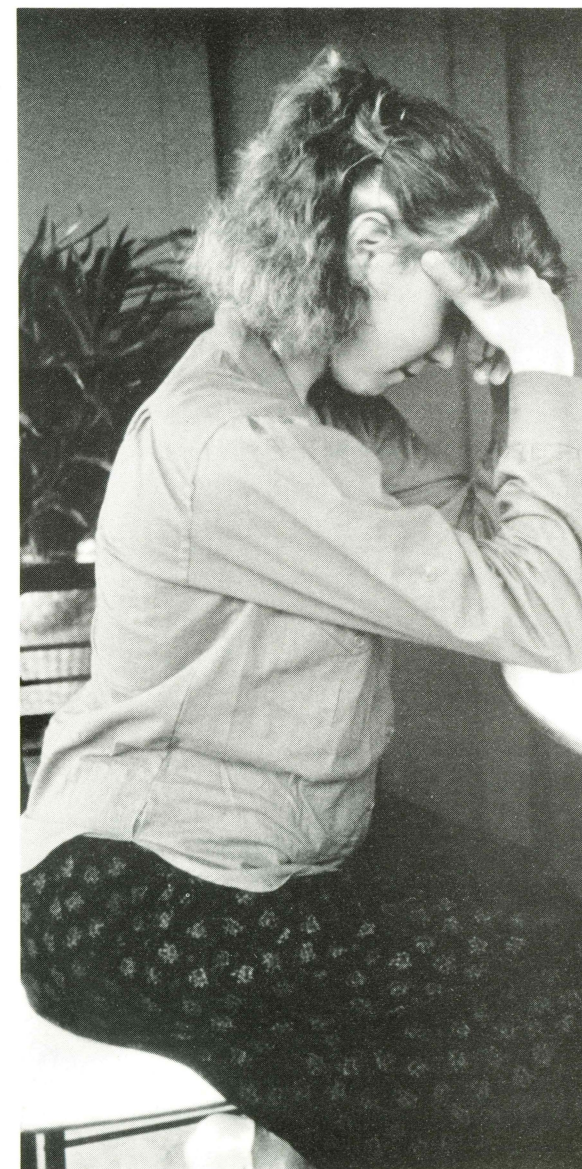
The stresses associated with adolescence often contribute to behavior such as truancy, sexual activity, stealing, and lying. Problems more easy to overlook such as headaches, abdominal discomfort, lack of energy, and isolation can also be identified in adolescents experiencing emotional stresses. Pregnancy can create stress not only to the teenager, but also to

her family, her partner and his family and, in many cases, this stress may create a crisis situation.

Community mental health centers provide individual counseling, information, education and referral services. The ability of community health centers to provide services targeted to pregnant adolescents is limited due to funding. Without separate programs for pregnant and parenting adolescents, their special mental health needs are not likely to be addressed. Providers of these services cite large numbers of teens who need but do not receive services. Extended case management, adequate support services, adequate housing, and transportation are common unmet needs of pregnant and parenting adolescents.

Income Assistance and Social Service Programs

One of the immediate consequences of a birth to a teen mother is the need to financially support the family. The major income assistance program available to eligible families is Aid to Families with Dependent Children (AFDC) for single-parent families, and the Unemployed Parent (AFDC-UP) program for husband-wife families. In addition to AFDC, eligible



families may also apply for and receive Food Stamps and medical assistance under the Medicaid program.

AFDC and Medicaid are federal-state programs under Titles IV-A and XIX of the Social Security Act respectively. The Food Stamp program is jointly administered by the state and federal governments, but the Food Stamp coupons are entirely federally financed. The programs in Missouri are administered by the Department of Social Services, and are approximately 60 percent funded by the federal government.

Based on expenditure estimates for fiscal year 1986, the Department of Social

Services paid out over \$225 million in AFDC, Medicaid, and Food Stamp benefits to mothers who had their first child as a teenager.

The table below summarizes these expenditures by program. These figures do not represent the total public cost of teenage parenting. Families may also be eligible to receive services from other state or local programs, such as prenatal care, emergency assistance, or education services.

As might be expected, the teenage public assistance population is primarily located in the State's three major urban areas.

The table below indicates the percentage of the teenaged public assistance population by program in each of those areas.

Child Welfare Services

For teenage parents, coping with the stresses and responsibilities of parenthood is a severe challenge. For many, simply learning how to care for a child is the most important need. Oftentimes, mere ignorance of parenting techniques leads to neglectful behavior; in conjunction with the stress of child-rearing and lack of income, the precipitating factors for child abuse are present. The vast majority of

Estimated Annual Expenditure on AFDC Cases Where the Mother Had Her First Child as a Teenager

(in millions of dollars)

	AFDC	Medicaid	Food Stamps	Total	Percent
Urban*	\$59.4	\$32.9	\$29.2	\$121.5	54%
Non-Metro	50.6	28.1	24.8	103.5	46%
Total	\$110.0	\$61.0	\$54.0	\$225.0	100%

*(includes St. Louis, St. Louis City and Jackson counties only)

teen parents neither neglect nor abuse their children, but for those who do, there are a variety of services available to alleviate the situation and provide any needed treatment.

The Division of Family Services (DFS) operates a statewide toll-free hotline to receive reports of child abuse/neglect. Over 40,000 calls are received annually, and lead to investigations of the complaints by social workers located in every county of the state. When the abuse or neglect is deemed serious, investigations are conducted jointly with law enforcement officials. In a study conducted by the Department of

Social Services, over a twelve-month period approximately six percent of all child abuse incidents found "reason to suspect" in the investigation included parents under age nineteen.

For those cases where a child has been abused or neglected, services are focused on keeping the family intact by providing services to the child and family. In some situations, however, protection of the child requires removal from the home. In these cases, the child may be placed in a family foster home, residential treatment center, or placed with relatives if a suitable arrangement is available. In both situations, there

is a variety of direct and purchased services available, including counseling, home-based services, parenting education and assistance, etc.

In addition to the child abuse/neglect hotline, DFS offers a telephone crisis counseling and referral service — the Parental Stress Helpline. Available seven days per week, 24 hours per day, trained social workers field calls from parents in stressful situations and, when necessary, make referrals to community agencies using an automated index of available service providers. This service was inaugurated to assist families before situations become crises and lead to abuse and neglect.

The most common service needed by teen parents is day care. For income-eligible families and for situations where day care can be therapeutic treatment, the Division of Family Services provides payments for children to enroll in licensed day care centers or homes while the parent(s) continues education, obtains job skill training, or seeks employment. In the current fiscal year, DFS subsidizes 5,600 children in day care, spending nearly \$8.4 million. The demand for day care exceeds the available resources, and in some areas of the state, there is a need for additional



licensed centers and homes to accept children.

Another major program operated by DFS is the adoption services and adoption subsidy program. Although the proportion of women who elect to allow their child to be adopted is small, DFS performs the necessary home study, matching, and placement services.

Child Support Enforcement

In far too many cases, the impoverishment associated with teen pregnancy is directly attributable to the absence of financial support from one of the parents, usually the father. Whether in or out of wedlock, parents are legally obligated to provide financial support for their children. The state has escalated its efforts to collect child support, and total collections have risen from \$2.6 million in 1978 to over \$31 million in 1985.

When a parent receives AFDC, support rights are assigned to the state, and collections from the absent parents go to the state treasury to offset public assistance costs. Under new legislation, however, the parent with custody of the child receives \$50 of the monthly support payments when there are no arrearages to be paid. Persons who do not receive AFDC may

also receive assistance in collecting child support due them.

The Division of Child Support Enforcement (DCSE) of the Department of Social Services is the agency that enforces the laws governing support obligation. DCSE has a wide spectrum of powers to enforce support obligations, including wage withholding, wage garnishment, liens for personal property, and intercept of federal and state tax refunds, and intercept of unemployment compensation.

We are not able to present specific data on adolescent parents and child support ordered and received. This population presents the most serious challenge to efforts to obtain and enforce orders for child support.

Employment and Training Programs

The Division of Job Development and Training (DJDT) is responsible for administering funds granted to the state under the Job Training Partnership Act (JTPA) and appropriate state matching funds. JTPA authorizes training activities designed to alleviate the specific employment problems of economically disadvantaged adults and youth served through both state and locally administered pro-

grams. The division must plan, manage, monitor and evaluate these employment and training programs to ensure effective implementation in Missouri.

Effective training occurs not only at the state level but at the local level as well. The division works with and allocates funds to 15 local service delivery areas which constitute the primary delivery unit for local programs. DJDT contracts with the Division of Vocational and Adult Education to coordinate institutional skill training in the service delivery areas. A private industry council and chief elected officials within each service delivery area then determine the types of programs to be offered and are responsible for day-to-day operations.

A broad range of training programs are allowable under JTPA, including but not limited to on-the-job and institutional skill training, work experience, remedial and basic education, job search assistance, and supportive services. In addition, the Act provides for optional programs specifically geared toward youth. These programs may include pre-employment skills training, tryout employment, and school-to-work transition assistance.

While job training is not a primary strategy for the prevention of teenage

pregnancy, the link between lack of good job prospects and teenage pregnancy is well established. Early parenthood can destroy the prospect of a successful economic and family career because most young parents lack the resources to repair the damage done by a poorly timed birth. Therefore, delaying parenthood is advantageous to the development of adolescents into productive and responsible adults. The desire, however, to postpone parenthood must come from the idea that there is something worthwhile, like education and a better job, by not becoming a parent. But the chronic unemployment and poor job prospects, particularly among minority youth, undermines the motivation to delay parenting.

While there are provisions in the Title II-A portion of the Job Training Partnership Act to serve youth, there are no programs specifically designed to serve pregnant or parenting teenagers. Services to this group are provided under the general JTPA programs. For example, within approximately two years (July 1, 1984 through June 4, 1986), 2,126 AFDC recipients age 14 through 19 were served. This is 12 percent of the youth served during this time. Of this number, 429 (20 percent) were single parents with a dependent under

the age of six. Pre-employment skills training, entry employment experience and work experience, accounted for 56 percent of the services provided. Twenty-three percent were placed in unsubsidized employment at an average wage of \$3.70 per hour.

The complex relationship among employment, education, literacy, cultural values, income and living environments argue that employment problems cannot be solved without first addressing issues of individual and family responsibility. The choices are not simply between on-the-job training and basic skills remediation programs for teenagers, but between investments in child care, pregnancy prevention, welfare reform and many other possible interventions.

Children's Trust Fund

As mandated by the legislature, the Children's Trust Fund (CTF) provides financial support for improvement in quality of life for many of Missouri's youth. Recognizing the critical nature of the pregnant and parenting adolescent, several projects receive financial support from the CTF. Projects enable the provision of support services to teenagers who are first-time parents by fostering community

support. Most projects develop and encourage parenting skills, and provide a framework for obtaining emotional support. Trained volunteers are used extensively and, in some projects, provide a one-to-one relationship for guidance and consolation.

Children's Services Commission

The Children's Services Commission is an interagency board created through legislation enacted in 1983. By law, it is the duty of the Commission to assist in the coordination of children's programs by state agencies; facilitate the elimination of duplicate efforts, programs and services; and develop an integrated state plan for the care provided to children and youth in this State through state programs.

Good parenting and the importance of families as stable, nurturing and loving supports to children's growth and healthy development is perhaps the most dominant theme which emerged repeatedly throughout the Commission's early inquiries into children's needs. The Commission promotes family well-being and the need for a greater public awareness of the family's importance to children's functioning.

Strategic Plan to Reduce the Incidence and Consequences of Adolescent Pregnancy and Parenting

Planning Assumptions

- Children live in communities and families, and it is communities and families — and adolescents themselves — that must be the source of solutions to the problem of adolescent pregnancy;
- Each person has a financial and moral responsibility to support his/her child(ren), whether in or out of wedlock;
- State government has a limited role given the primacy of cultural and familial values affecting personal behavior, but does have the responsibility to ensure that basic human needs are met, especially for children; and
- The public must be better educated about the problem of adolescent pregnancy and its solutions.

GOAL I: Reduce the Incidence of Adolescent Pregnancy

Objective A. Encourage adolescents to postpone sexual activity.

Strategy 1. Promote family involvement in programs that strengthen positive parent/child relationships.

Strategy 2. Focus programs on basic family communication skills that promote adolescent responsibility.

Strategy 3. Community institutions, such as PTAs, churches, etc., should develop decision-making programs encouraging adolescents to postpone sexual activity.

Objective B. Enable all children to obtain comprehensive health education including life skills instruction, through local school districts to promote the well-being of each child.

Strategy 1. The Department of Health and the Department of Elementary and Secondary Education should jointly assist local school districts to define comprehensive health programs appropriate for their students.

Strategy 2. The State Board of Education should revise and develop additional model comprehensive health education curricula and materials and encourage local school districts to integrate such programs into their curriculum.

Strategy 3. Encourage more local school districts to have a high school graduation requirement of comprehensive health education.

Objective C. Encourage the leadership of government, business, education, and the media to promote and develop teen pregnancy prevention programs.

Strategy 1. The Departments of Health, Elementary and Secondary Education, and Social Services should implement a media campaign directed at adolescent pregnancy prevention.

Strategy 2. The state departments should solicit the cooperation of the private sector, especially the media, in financing and conducting the statewide media campaign.

Strategy 3. A portion of this campaign should be specifically targeted to encourage adolescents to postpone sexual activity.

Objective D. Explore the establishment of comprehensive health services in the schools in order to promote healthy lifestyles, including education, medical care, and counseling accessible to and appropriate for teens.

Strategy 1. Local health departments and local school districts should work with parents to identify the health needs of adolescents in their communities.

Strategy 2. Local school districts and local health departments should consider existing school-based health clinic programs for possible local adaptation.

Strategy 3. The Department of Health should provide technical assistance to local groups in this effort.

Objective E. Target teen pregnancy prevention programs to adolescent males as well as females.

Strategy 1. Encourage family life education programs be directed at adolescent males as well as females.

Strategy 2. Media campaigns should pay particular attention to encouraging males to accept their responsibility.

Objective F. Encourage adolescents to postpone parenthood by increasing teenagers' positive views of their future opportunities and themselves.

Strategy 1. Encourage family life education programs be directed at adolescent males as well as females.

Strategy 2. The State, in cooperation with employers and the Private Industry Councils, should expand school-to-work transition programs and work-study opportunities.

Strategy 3. Increase availability of job exploration, counseling, and career decision-making skills, including short-term job search assistance, job clubs, and follow-up services for adolescents.

Objective G. The State, employers, and local communities should take steps to address the chronic and worsening high rate of adolescent unemployment, particularly among minorities.

Strategy 1. Target JTPA youth programs on high-risk youth.

Strategy 2. Community development strategies should include aggressive marketing and job development with businesses to hire this population.

Strategy 3. Expand work experience programs, especially summer jobs programs, to prepare youth for the labor market.

GOAL II: *Reduce the Consequences of Adolescent Pregnancy*

Objective A. Establish programs to assist adolescent parents to finish high school.

Strategy 1. Provide on-site day care in schools for children of adolescent parents who wish to complete their high school education.

Strategy 2. When necessary, alternative transportation services should be made available.

Strategy 3. Local school districts should explore innovative programs that encourage adolescents to remain in or return to school.

Objective B. Target employment and training programs to adolescent parents to increase life options and increase the sense of financial responsibility.

Strategy 1. Encourage the use of remedial education in conjunction with skill training and work experience in such programs.

Strategy 2. The Departments of Labor, Elementary and Secondary Education, Economic Development, and Social Services should implement interagency programs to promote job placements, including the provision of support services, such as child care.

Objective C. Increase the opportunities for adolescents to participate in group and individual parenting education classes.

Strategy 1. Local school districts, local health departments, and social service agencies should develop/expand parent education programs for use throughout the community.

Strategy 2. Increase the involvement of local medical and mental health societies in the development and implementation or expansion of parent education programs.

Strategy 3. Support the involvement of churches, religious groups, and ministerial alliances in parent education programs.

Objective D. Encourage families and community institutions — PTAs, churches, etc. — to provide the awareness in young people of the responsibility of parenthood.

Strategy 1. Develop media and education programs to communicate to adolescents all of the responsibilities of childrearing, from the economic costs to the health, social, and emotional responsibilities.

Strategy 2. Efforts should be undertaken by health and social service agencies to promote the involvement of the father in the care and support of his child(ren).

Strategy 3. The Department of Social Services should vigorously pursue the enforcement of child support.

Strategy 4. Courts should require unmarried teen males, where paternity and child support order has been established, to enroll in employment/training programs.

Objective E. Increase access to prenatal and primary health care for children and their families.

Strategy 1. Develop and promote a network of health care providers at the local level to cooperatively provide needed health services.

Strategy 2. The Department of Health, in cooperation with the Department of Elementary and Secondary Education, should provide school nurses with specialized training in the area of prenatal care, adolescent pregnancy and post-pregnancy infant care with faculty consultation.

Strategy 3. The Departments of Health and Social Services should explore mechanisms to ensure health care services to medically indigent adolescents.

Objective F. Increase the availability of quality, affordable day care so that teen parents can participate in educational and job training programs.

Strategy 1. Provide subsidized day care to adolescent parents enrolled in educational and job training programs.

Strategy 2. The State should assist employers to develop on-site day care programs.

Objective G. Government policies and programs, at federal and state levels, should encourage minor parents to remain with their adult caretakers.

Strategy 1. The Department of Social Services should work with the federal government to develop policies in the AFDC program that encourage minor parents to remain with their adult caretakers.

Strategy 2. The “Grandparent Liability” law enacted by the State of Wisconsin should be carefully assessed for the success/failure of holding parents responsible for the offspring of their minor children.

In conclusion, we cannot emphasize enough the importance of families and family-supporting institutions — schools, churches, neighborhoods, civic organizations, etc. — in the solutions to the problems posed by adolescent sexual activity, pregnancy, and parenting. The role of state services can best be described as a support to efforts in the communities across the state. State services can never replace the role of the family nor the cultural institutions that, ultimately, arise from the family.

What we have attempted to construct is a long-range framework for the coordination and delivery of state services. We have not attempted to prioritize these recommendations since it is often the interaction of the recommendations that is so vital. The complexity of the problem requires that solutions be advanced on many fronts simultaneously.

We believe that the recommendations contained in this report will make great strides in reducing the incidence and consequences of adolescent pregnancy. But implementing these recommendations will take a concerted effort by all Missourians. It is a difficult and challenging task, but one that we must not only accept, but welcome.



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